



Improving Oversight and Coordination of Department of Defense Programs That Address Problematic Behaviors Among Military Personnel

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For more information on this publication, visit www.rand.org/t/RR1352

Library of Congress Cataloging-in-Publication Data

ISBN: 978-0-8330-9568-8

Published by the RAND Corporation, Santa Monica, Calif.

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Preface

The U.S. Department of Defense (DoD) has begun to search for an integrated solution to a range of behaviors that members of the military exhibit that have had an adverse impact on operational readiness or on the well-being of service members and their families—behaviors that DoD calls *problematic*. After nearly two decades of persistent conflict and facing declining resources, the military services have taken steps in recent years to integrate the management of programs that address both positive and negative behaviors affecting personnel readiness and resiliency. Although the Office of the Secretary of Defense (OSD) has followed a largely stovepiped approach to behavioral program supervision, the Office of Diversity Management and Equal Opportunity (ODMEO) asked the RAND Corporation to help identify options for improving OSD's coordination and oversight of efforts to mitigate problematic behavior among military personnel.

This final report provides the results of the RAND study examining the integration of programs for addressing a particular set of problematic behaviors: sexual harassment, sexual assault, discrimination, substance abuse, suicide, and hazing. ODMEO selected these behavioral programs because they fell within the full or partial purview of the military deputy to the Under Secretary of Defense for Personnel and Readiness at the time of our research and because they provided a good basis for integrative analysis. The report combines the results of the two major lines of research: the first related to the development of a typology of common risk and protective factors and prevention methods for problematic behavior, and the second related to the organization, coordination, oversight, and managerial practices of programs at the DoD-wide and service levels to address problematic behavior. Following the discussion of findings from the two lines of research, the report lays out a series of recommendations for OSD going forward.

This report should be of interest to those who are interested in learning about what DoD is doing to address problematic behavior among military personnel. This report examines opportunities and options for DoD to improve oversight and coordination among the many DoD organizations involved in addressing these problematic behaviors.

This research was sponsored by ODMEO and conducted within the Forces and Resources Policy Center of the RAND National Defense Research Institute (NDRI), a federally funded research and development center sponsored by the Office of the Secretary of Defense, the Joint Staff, the Unified Combatant Commands, the Navy, the Marine Corps, the defense agencies, and the defense Intelligence Community.

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Contents

| | |
|--|-----|
| Preface | iii |
| Figures and Tables | vii |
| Summary | ix |
| CHAPTER ONE | |
| Introduction | 1 |
| Background | 1 |
| Objectives | 3 |
| Office of the Secretary of Defense and Service Responsibilities for Managing Problematic Behavior | 6 |
| Approach | 8 |
| Organization of This Document | 9 |
| CHAPTER TWO | |
| Identifying Common Risk Factors Across the Six Problematic Behaviors | 11 |
| Methods | 11 |
| Developing the Conceptual Model and Common Risk Factors | 12 |
| Assessing Problematic Behavior in Terms of Common Risk Factors | 16 |
| Summary | 36 |
| CHAPTER THREE | |
| Identifying Common Prevention Interventions for the Six Problematic Behaviors | 39 |
| Prevention-Strategy Selection and Linkage to the Conceptual Model | 39 |
| Assessing Prevention Strategies for Addressing the Six Problematic Behaviors | 40 |
| Summary | 55 |
| CHAPTER FOUR | |
| The Office of the Secretary of Defense’s Strategic-Level Organization to Address Problematic Behavior | 57 |
| What Organizations Are Involved in Addressing Problematic Behavior, and How Are They Structured? | 58 |
| What Coordination and Oversight Mechanisms Are Currently Being Used? | 69 |
| How Well Are Office of the Secretary of Defense Organizations Managing Problematic Behavior? | 72 |
| Summary | 82 |

CHAPTER FIVE

| | |
|--|----|
| Structural Alternatives for Addressing Problematic Behavior Within the Office of the Secretary of Defense | 85 |
| What Structural Alternatives Are Found in the Organizational Literature?..... | 85 |
| Alternative Structures Within the Services | 88 |
| Insights for the Office of the Secretary of Defense from Analysis of the Structural Alternatives in Military Departments | 94 |

CHAPTER SIX

| | |
|--|-----|
| Conclusions and Recommendations | 97 |
| Behavioral Research Conclusions and Recommendations | 98 |
| Programmatic Analysis Conclusions and Recommendations..... | 100 |

APPENDIXES

| | |
|---|-----|
| A. Prevalences of Six Problematic Behaviors Within the Military | 105 |
| B. Interview Protocol | 111 |
| C. Service Organizations to Address Problematic Behavior and Perspectives on Office of the Secretary of Defense Oversight and Coordination | 115 |
| Acknowledgments | 131 |
| Abbreviations | 133 |
| Bibliography | 137 |

Figures and Tables

Figures

| | | |
|------|--|----|
| 1.1. | Interconnection Between the Office of the Secretary of Defense and the Services in Dealing with Problematic Behavior | 7 |
| 2.1. | Conceptual Model Describing a Common Process Leading to Problematic Behavior.... | 13 |
| 3.1. | Strategy Selection and Linkage to the Conceptual Model..... | 40 |
| 4.1. | Office of the Secretary of Defense Organizations That Address Sexual Assault | 60 |
| 4.2. | Office of the Secretary of Defense Suicide Prevention Organizations..... | 62 |
| 4.3. | Office of the Secretary of Defense Organizations Addressing Substance-Use Organizations | 65 |
| 4.4. | Office of the Secretary of Defense Organizations Addressing Sexual Harassment and Discrimination..... | 68 |
| 4.5. | Office of the Secretary of Defense Antihazing Organization | 70 |
| 5.1. | Functional Departments in a Manufacturing Company | 86 |
| 5.2. | Self-Contained Product Departments in Manufacturing..... | 86 |
| 5.3. | Matrix Organizational Structure | 87 |

Tables

| | | |
|------|--|-----|
| S.1. | Recommendations for Policy Addressing Problematic Behavior..... | xv |
| 2.1. | Cross Between Problematic Behaviors and Risk Factors..... | 17 |
| 3.1. | Cross Between Problematic Behaviors and Prevention Strategies..... | 41 |
| 4.1. | Summary of Office of the Secretary of Defense's Efforts to Coordinate Addressing Problematic Behavior..... | 71 |
| 4.2. | Summary of Office of the Secretary of Defense's Efforts for Oversight of Problematic Behavior..... | 72 |
| 4.3. | OSD Management of Programs to Address Problematic Behavior..... | 83 |
| A.1. | Co-Occurring Factors in Service Members Who Died by Suicide, All Services, 2013 | 108 |

Summary

Introduction

Pressures inside and outside the U.S. Department of Defense (DoD) to reduce the incidence of problematic behavior¹ within the military without a significant increase in additional resources are inducing OSD to rethink how it is organized to provide policy guidance and oversight of the department's numerous behavior-mitigation efforts. This means reconsidering the default institutional response of setting up a new program or task force to address each behavioral issue as it surfaces in the popular and congressional consciousness and, instead, developing a streamlined and integrative framework for addressing a range of related problematic behaviors. This is easier said than done. It continues to be a difficult task to determine what constitutes problematic behavior in a military context, how these behaviors should be categorized, and how much coordination there should be in the efforts to prevent and respond to them.

The Office of Diversity Management and Equal Opportunity within OSD, in consultation with the military deputy to the Under Secretary of Defense for Personnel and Readiness (USD[P&R]), asked RAND to help OSD develop an integrative framework for preventing and modifying problematic behavior among military personnel by identifying options to improve its coordination and oversight related to six specified problematic behaviors:

- sexual harassment
- sexual assault
- unlawful discrimination
- substance abuse
- suicide
- hazing.

The sponsor selected these six behaviors because, with the exception of sexual assault, they all fell (at the time) within the full or partial purview of the USD(P&R)'s military deputy. Although this set of behaviors provided a reasonable basis for our analysis, we acknowledge that we could have included other behaviors in our study—in particular, family violence, for whose prevention the Deputy Assistant Secretary of Defense for Military Community and Family Policy has oversight responsibility.

¹ For this study, individual or collective behavior is considered problematic if the Office of the Secretary of Defense (OSD) has deemed it to be sufficiently detrimental to operational readiness or the well-being of service members and their families that it has organized an effort to address the behavior.

To provide options for improved integration, the RAND team **reviewed behavioral research**, examining the academic literature to answer three questions:

- What are the risk factors associated with problematic behavior?
- What are the recommended methods for preventing problematic behavior?
- How are the above factors and methods similar and different?

To answer those questions, the research team sought to identify risk factors common across the six problematic behaviors and then to identify strategies that have been employed to prevent each.

The team also **conducted programmatic research**—via policy discussions, document analysis, and a review of the organizational design literature—to gain an understanding of existing organizations and practices within OSD to address problematic behavior and to explore alternative structural models. In particular, we sought answers to four questions:

- What OSD organizations are involved in addressing problematic behavior, and how are they structured?
- What coordination and oversight mechanisms are OSD organizations using?
- How well managed are OSD organizations to address problematic behavior in terms of their conformity to recognized managerial principles?
- What alternatives exist to OSD's current organizational structures that suggest ways in which OSD might improve its oversight and coordination of programs to address problematic behavior?

To answer the last question, we explored basic departmental alternatives outlined in the organizational design literature and reviewed actual alternative structures within the services, which not only share managerial responsibility with OSD for dealing with problematic behavior in the military but have also taken steps in recent years to integrate their behavioral programs.

Finally, drawing on the results of the behavioral and programmatic research, we answered two **overarching questions**:

- To what extent should programs to address problematic behavior be integrated?
- If they are integrated, in what ways should that occur?

Key Findings

Informed by the behavioral and programmatic research, we identified some key findings. For each of the lines of research, we first present an overview of our findings and then provide a more detailed description.

Behavioral Research Findings

The existing academic literature cannot serve as a guide for determining the full extent of desirable behavioral program integration within OSD. Not so differently from the Pentagon with its penchant for organizational stovepiping, the scientific community has tended to study

problematic behaviors in isolation from one another. Nevertheless, our behavioral analysis does present considerable empirical evidence about general risk factors that are shared across multiple behaviors—that is, attitudes about problematic behavior, an organizational climate that fosters or discourages the problematic behavior, and access to the means to engage in the problematic behavior. Furthermore, our research shows that these factors are linked and could be targeted by multidimensional prevention strategies that address

- the propensity to engage in problematic behavior through screening, education, and attitude-modification programs
- ways to inhibit problematic behavior through changes in organizational norms and culture, bystander programs, access to mental health treatment, and policy innovations
- restriction of the means to engage in problematic behavior through various policy, legal, and administrative actions.

Finally, the fact that we have identified few academic studies that examine the relationships among problematic behaviors suggests the need for DoD to take the lead in conducting such research to provide an evidentiary basis for its proposed integrated organizational approach to enhancing the health and well-being of service members and their families.

Risk and Protective Factors

With the exception of hazing, the academic literature has established many of the risk and protective factors related to the identified problematic behaviors. One of our principal findings is that attitudes seem to predict problematic behavior best when organizational context also supports the behavior. In other words, someone is more likely to engage in problematic behavior, such as sexual harassment, if that person perceives that peers and leaders explicitly or implicitly condone those actions. Conversely, people who might be initially inclined toward problematic behavior can be dissuaded if the organizational climate is clearly in opposition to such behavior.

Another finding is that limiting access to the means of performing a problematic behavior (e.g., alcohol, guns, relationship of authority) can reduce the likelihood of the behavior (e.g., alcohol misuse, suicide, sexual harassment) occurring. That said, practical and legal constraints could preclude anti-access-based prevention strategies. To guard against the possibility that one type of strategy might prove insufficient or ineffective, the best approach might be one that addresses all three categories of risk and protection (attitudes, organizational climate, and access to means).

Our last finding is that the scientific literature provides some links among problematic behaviors; alcohol use is a clear risk factor for suicide and sexual assault, and recent RAND research on sexual assault has demonstrated its association with sexual harassment and hazing. However, the fact that academic literature is stovepiped has meant that there have been relatively few studies on the interrelationships among multiple problematic behaviors.

It should be noted that our review of risk and protective factors was not intended to be exhaustive. Given our mandate to investigate potential areas for collaboration across agencies, we adopted a conservative approach, limiting our review to settled, replicated science. The scientific knowledge base on risk and protective factors is still growing, and greater understanding is needed with respect to the full set of unique and overlapping factors that can reliably predict problematic behavior.

Prevention Strategies

Our research on the literature related to prevention strategies indicates that combined prevention strategies relying on common principles could be developed for multiple problematic behaviors. Although holistic prevention strategies have only recently been adopted in the military, there is some precedent for combined risk-tracking across problematic behaviors to guide the delivery of indicated prevention programs (e.g., the Air Force's suicide risk-tracking program). Methods found to be effective for preventing or treating a specific problematic behavior might also be effective for other behaviors. However, because of the traditional tendency of scientists and practitioners to focus on single behaviors, as well as for behavioral research and program implementation funding to be distributed unevenly, prevention strategies have not usually been evaluated in different behavioral contexts. Of course, employing similar prevention strategies to address multiple problematic behaviors makes sense only if the methods used are effective and target a shared underlying risk factor. To narrow the review to the most-compelling evidence, we restricted our summary to prevention strategies that had been implemented and evaluated in organizations, and we prioritized evidence from experimental or quasi-experimental trials when available. The results of our literature review indicate that specific programs or practices have rarely had a measurable impact on reducing the incidence of a problematic behavior; however, they do point to areas of strategic convergence, as well as potential gaps along the prevention spectrum at which program and research efforts might be applied, with the expectation that a multidimensional, integrated approach might work better than a behavior-by-behavior, disconnected strategy.

Programmatic Analysis Findings

Our qualitative analysis of OSD organizations that address problematic behavior suggests the need to consider modifications in how OSD oversees and coordinates efforts to prevent problematic behavior. OSD programs to address problematic behavior vary substantially in terms of unity of command, mission focus, span of control, collaboration, quality of planning and assessment processes, and adequacy of resources. In some ways, this is neither surprising nor necessarily inappropriate. An organization's design is contingent on the environment in which it operates; the kind of problems addressed, the extent of responsibilities, and the priority given to the OSD offices we examined differ considerably. Nevertheless, our discussions with program officials and our review of existing policy and strategy documentation indicate that some of the practices that OSD employs to address certain problematic behaviors do not conform to basic managerial principles, i.e., unity of command, mission focus, span of control, collaboration, quality of planning and assessment processes, and adequacy of resources.

The findings from our research into structural alternatives for addressing problematic behavior are less prescriptive than they are suggestive of approaches that OSD could take once the leadership has formulated a comprehensive vision for behavioral health and readiness based on an improved understanding of the interconnections among behavioral risks, protective factors, and prevention and promotion strategies. According to organizational design theory, self-contained structures, which are focused on products or services and contain all the occupational elements needed to perform their tasks, are better suited to achieving oversight and coordination objectives than functionally based organizations, whose major departments are arranged based on occupational skills, are. Moreover, our analysis of service headquarters organizations shows a trend toward self-contained structures that encompass multiple behaviors. Still, these larger structures are designed mostly for coordination purposes. Thus far, indi-

vidual service programs to address problematic behavior continue to have separate reporting chains that are connected to their counterpart offices in OSD.

Oversight

Some OSD organizations that are responsible for overseeing DoD's efforts to deal with problematic behavior—sexual assault, in particular—have institutionalized many of the managerial principles noted above, for example, by establishing a clear authority structure, a focused mission, and a strategic plan that ensures accountability. However, other organizations—including those responsible for addressing unlawful discrimination and sexual harassment, suicide, and substance abuse—lack adequate policies, plans, information systems, and resources needed to establish a departmental approach to certain behavioral issues, to inform senior leadership about these problems, and to ensure that the leadership's decisions about problematic behavior are being uniformly enforced. Hazing, especially, represents a significant gap in DoD's framework for mitigating problematic behavior. Although the Office of Diversity Management and Equal Opportunity is chairing a working group charged with addressing this issue and has recently issued a memorandum that more clearly defines this problematic behavior, the department still does not have a policy that spells out how the services and other defense organizations are to reduce the incidence of hazing.

There is also a need for better OSD-supervised tracking and accountability mechanisms for problematic behavior. In the Army, for example, only formal (written and sworn) sexual harassment complaints are reported up the chain of command, while informal complaints are resolved at the lowest possible level and not tracked, which hampers understanding of the extent and nature of the problem. Also, our discussions with OSD and service officials indicate that personnel and funds for some efforts to address problematic behavior are being stretched to the point that mandated tasks cannot be done or cannot be done well within specified time periods. This is particularly the case in OSD's Military Equal Opportunity program, in which a single person has had nominal oversight responsibility for all DoD programs that address sexual harassment and discrimination issues among military service members. Without a permanent support staff, however, the Military Equal Opportunity Office has had difficulty issuing up-to-date policy guidance, much less ensuring policy compliance.

OSD's complex governance structures for tackling suicide and, especially, substance abuse within the military also inhibit effective oversight. Although designated as the focal point for suicide prevention policy, at the time of our research, the Defense Suicide Prevention Office (DSPO) was under the operational control of one organization, was resourced by another organization, and received guidance from three different governing boards. Whereas suicide prevention at least has a central programmatic authority, albeit a weak one, the arena of substance-abuse policy is, for the most part, functionally organized; it has no self-contained structure, except for the drug-testing program. This diffusion of responsibility across health, personnel management, and other functions makes it inherently difficult to craft a comprehensive behavioral strategy or to establish a mechanism for monitoring policy compliance and behavioral outcomes in all the functional areas pertinent to substance abuse.

Coordination

Currently, OSD does not have a single organization responsible for coordinating efforts to prevent, treat, and respond to the range of problematic behaviors examined in this report. Instead, many OSD offices and agencies address different functions related to different behaviors. In

part, this is understandable given that the expertise and the authority to perform certain functional activities involving problematic behavior reside in specific organizations and cannot be easily combined within one entity. In addition, although recent RAND research on sexual assault has demonstrated the relationship between this problematic behavior and sexual harassment and hazing, there is limited research on the connections among several of the problematic behaviors we reviewed. That said, the argument for improved coordination of organizations within OSD that address problematic behavior is supported by the facts that OSD has only so many resources to devote to overseeing departmental efforts aimed at addressing problematic behavior and that these resources are distributed widely and unevenly. Thus, a more coordinated approach could be helpful from the cost-and-benefit standpoint if there were more and broader evidence of risk and protective factor linkages and programmatic effects on multiple behaviors.

Obstacles to coordination exist among OSD organizations dealing with issues pertaining to individual and multiple behaviors. As just mentioned, an overly complicated management structure hampers substance-abuse policy development and implementation. To bring together various functional interests, multiple coordinating bodies have been established at different levels of the department. Also, the complex governance structure for suicide prevention within the Office of the USD(P&R) has constrained its ability to coordinate the activities of DoD programs that target this problematic behavior. Furthermore, existing bureaucratic processes and varying levels of resources do not enable OSD organizations focused on different but related problematic behaviors, such as sexual assault and sexual harassment, to easily work with each other. As a result, OSD treats behaviors separately for the most part. By contrast, although they still retain individual offices for each problematic behavior, the services (in particular, the Army and the Navy) are beginning to undertake a holistic approach to behavior management.

Caveat

Before turning to our recommendations, we provide the following caveat with respect to our programmatic findings. Information in this report reflects organizational arrangements within OSD as of the end of October 2015, when we completed our data collection, analysis, and writing. Subsequent to that date, reorganization has occurred, and new positions have been created, such as changes in the military deputy's portfolio and the establishment of an executive director of the Office of Force Resiliency in the Office of the USD(P&R). Nevertheless, even as changes occur in OSD's organizational structure, we believe that information and analysis in this report provide a foundational understanding of OSD's management of problematic behavior, the major issues and challenges that OSD faces, and OSD's goals for addressing problematic behavior.

Recommendations

Given the behavioral and programmatic research findings, we offer a series of recommendations, broken into the two sets of subcategories discussed previously; these are summarized in Table S.1 and explained in more detail in the text. Given the breadth and complexity of some of these recommendations and the need for substantial cooperation throughout the department to ensure that they are effectively carried out, we suggest that the USD(P&R) create a

Table S.1
Recommendations for Policy Addressing Problematic Behavior

| Recommendation Type | Category | Recommendation |
|-----------------------|-----------------------------|--|
| Behavioral research | Risk and protective factors | <p>Review existing assessment systems that monitor the role of cultural and climate factors in promoting or inhibiting problematic behavior, and modify these systems where there are coverage gaps or methodological problems.^a</p> <p>Review existing service policies intended to restrict access to the means to engage in problematic behavior, and consider applying elsewhere in DoD those policies that have been shown to be effective.</p> <p>Consider ways to leverage existing DoD data to continue to explore connections among problematic behaviors.</p> |
| | Prevention strategies | <p>Review the effects that prevention and response strategies that DoD is currently using to cope with individual problematic behaviors can have on other (nontarget) behaviors.^a</p> |
| Programmatic research | Oversight | <p>Review departmental staffing levels for the oversight of problematic behavior, especially hazing and sexual harassment; in strategic plans, prioritize tasks to address problematic behavior, and ensure that policy mandates can be implemented within resource limitations and timelines.^a</p> <p>Ensure the development of strategic plans for sexual harassment, and complete the substance-misuse strategic plan.^a</p> <p>Approve definitions that distinguish hazing from bullying, and establish policies and procedures for reducing the incidence of both kinds of problematic behavior.</p> <p>Develop clear and common definitions, standards, and submission protocols for behavior data that the services collect and report to OSD.</p> <p>Examine the pros and cons of establishing an OSD program that would have policy and oversight responsibility for prevention of and response to substance (including alcohol) abuse.</p> <p>Consider increasing DSPO's authority to oversee suicide prevention programs in DoD, including requiring the services to provide data to DSPO on suicide prevention program performance and effectiveness.</p> |
| | | <p>Consider streamlining OSD management of certain problematic behaviors, either by establishing self-contained programs or by developing a matrix structure with functionally integrated programs whose personnel report to both senior functional and program managers.^a</p> <p>To understand where gaps might lie with respect to collaboration, review OSD coordinating bodies and activities that address problematic behavior.</p> <p>Encourage the services to monitor and evaluate innovative holistic approaches to behavioral management.</p> |
| | Coordination | |

^a The study team believes that this should receive high-priority consideration by the proposed senior-level task force on integrating programs to address problematic behavior.

senior-level task force—chaired jointly by the USD(P&R) military deputy, the new executive director of the Office of Force Resiliency, the Assistant Secretary of Defense for Health Affairs, and Assistant Secretary of Defense for Manpower and Reserve Affairs and including representatives from the military services, the National Guard Bureau, and relevant defense agencies—that would be responsible for issuing guidance on improving the integration of OSD's efforts to address problematic behavior within the military and for overseeing the implementation of such guidance.

In sum, OSD can do much to improve its organizational response to existing and emerging problematic behaviors. With some notable exceptions, there is little definitive scientific research on connections between different problematic behaviors. Therefore, pursuing integrated solutions to behavioral problems should be treated as testable experiments at present. In addition, OSD should take steps to improve how its offices oversee and coordinate DoD efforts against particular behaviors by completing policies and plans, expanding tracking and accountability mechanisms, establishing self-contained programs with wider oversight responsibilities, and consolidating coordinating bodies without decreasing collaborative opportunities. A high-level, permanent body responsible for overseeing and coordinating policies and programs to prevent problematic behavior might make sense at some point in the future and should be explored in cases in which behavioral linkages are clear. However, if OSD leaders decide on such an approach, they should first review the lessons learned by service headquarters organizations responsible for integrating programs designed to curtail problematic behavior and increase the resilience of service members.

Introduction

Background

Recently, the Office of the Secretary of Defense (OSD) has been reconsidering how it is organized to provide policy guidance and oversight of the department's varied behavior-mitigation efforts. Under intense scrutiny from the media and Congress in recent years because of its perceived mishandling of sexual assault and suicide cases, the U.S. Department of Defense (DoD) has created high-level, single-purpose organizations within OSD and the services—such as the Sexual Assault Prevention and Response (SAPR) Office (SAPRO) and the Defense Suicide Prevention Office (DSPO)—to address issues related to preventing and responding to these problematic behaviors.¹ There has been less bureaucratic focus recently on other forms of problematic behavior, such as sexual harassment and unlawful discrimination, likely because these behaviors have not received a great deal of outside attention and because DoD has well-established military equal opportunity (EO) (MEO) organizations in the services responsible for addressing these problems. That said, there is some concern that OSD cannot provide adequate oversight of antidiscrimination and anti-sexual harassment policy implementation.² Also, emerging behavioral problems, such as hazing, do not fit well into the existing mitigation structure in OSD or the services.

Like the rest of DoD, organizations dealing with problematic behaviors must contend with the related challenges of sequestration and defense reform. With the partial relief that the bipartisan budget compromise of 2013 offered possibly coming to an end, programs across the department will face the prospect of additional funding cuts.³ Although the suicide prevention and SAPR program offices are relatively well resourced at this point, they might be hard pressed to continue to meet their strategic objectives and the requirements that Congress imposes on them with current levels of funding and personnel. And DoD proponents of less salient behavioral issues might have to make do with fewer resources than they currently have. For defense reformers, cost-cutting could be accomplished partly by overhauling the

¹ For this study, individual or collective behavior is considered problematic if OSD has deemed it to be sufficiently detrimental to operational readiness or the well-being of service members and their families that it has organized an effort to address the behavior.

² Military Leadership Diversity Commission, *From Representation to Inclusion: Diversity Leadership for the 21st-Century Military—Final Report*, Arlington, Va., March 2011, p. xvii.

³ Heidi Przybyla, "Defense Cuts Stirring Republican Congress Confronting New Budget," Bloomberg, November 21, 2014.

Pentagon's stovepiped bureaucracy.⁴ With respect to problematic behaviors, this would mean reconsidering DoD's default institutional response of setting up a new program or task force to address each behavioral issue as it surfaces in the popular and congressional consciousness and shifting instead to developing a streamlined and integrative framework for addressing a range of related behaviors.

There is no consensus within DoD on a general strategy to address problematic behavior. Indeed, it continues to be a difficult task to determine what constitutes problematic behavior in a military context, how these behaviors should be categorized, and how much coordination there should be in the efforts to prevent and respond to them. In 2015, for example, the Joint Staff High-Risk Behavior Working Group advised against continuing to use the term *high-risk behavior* because it equated risky behaviors that were positive and negative from a military standpoint, because it could refer to either an adverse outcome or a risk factor for an adverse outcome, and because it placed the focus on individual behaviors rather than organizational contributions to adverse outcomes. It recommended instead employing a combination of related terms to describe the full scope of behavioral elements affecting military health and readiness, including *adverse outcome*, *adverse state*, *risk factor*, *counterproductive behavior*, and *protective resource*.⁵

We recognize the conceptual issues involved in using a single term to cover a range of disparate behaviors with complex interrelationships. However, given our interest in a particular set of behaviors, we have not seen the need to develop or appropriate a complex combinatory framework to generally define what we mean by *problematic behavior*. Thus, for this study, an individual or collective behavior is problematic if OSD has deemed it to be sufficiently detrimental to operational readiness or the well-being of service members and their families that it has organized an effort to address the behavior.

Fortunately, those seeking answers to organizational questions related to problematic behavior have a variety of places to turn for useful evidence and examples. Most of the services are already experimenting with various approaches to strengthening and integrating the management of programs to address problematic behavior.⁶ The aforementioned working group recommended that DoD "better coordinate and integrate military public health, prevention, wellness, safety, and medical programs," including establishing an Office of Personnel Risk Reduction within the Office of the Under Secretary of Defense for Personnel and Readiness

⁴ For example, see Council on Foreign Relations, "A Conversation with Michèle Flournoy," transcript, Paul C. Warnke Lecture on International Security, April 17, 2013.

⁵ An adverse outcome is any negative health or social outcome, including avoidable deaths, injuries, illnesses, legal infractions, and family disruptions. An adverse state is a condition in an individual, family, unit, or service created by risk factors for adverse outcomes exceeding protective resources. A risk factor is any factor in an individual, family, unit, or service that increases the likelihood of an adverse outcome. Counterproductive behavior is a subset of risk factors for adverse outcomes that can exist in any socioecological domain (i.e., service members, leaders, family members, and entire units can engage in counterproductive behaviors). A protective resource is any factor in an individual, family, unit, or service that reduces the likelihood of an adverse outcome and promotes positive outcomes; the term *resource* was chosen to highlight the perishable nature of factors that protect against adverse outcomes. See Joint Staff High-Risk Behavior Working Group, *Promoting Trust, Enhancing Resources, and Reducing Risk: Final Report*, May 29, 2015, p. 9.

⁶ Service organizations and frameworks intended to integrate a variety of behavioral health initiatives include the Army Resiliency Directorate (ARD), the Navy's 21st Century Sailor and Marine initiative, the Air Force's CAF program, and the Marine Corps Behavioral Health Program.

(USD[P&R]).⁷ Also, the behavioral science community inside and outside DoD has made some strides in explaining the connections among problematic behaviors, which might suggest better ways of managing and coordinating prevention efforts.

Objectives

The Office of Diversity Management and Equal Opportunity (ODMEO) within OSD asked RAND to help OSD develop an integrative framework for preventing and modifying problematic behavior among military personnel by identifying options to improve OSD-level coordination and oversight related to specified behaviors. The problematic behaviors that ODMEO asked us to examine for potential inclusion in OSD's integrative framework are

- sexual harassment
- sexual assault
- unlawful discrimination
- substance abuse⁸
- suicide
- hazing.

At the time of this study, all the behaviors described above, with the exception of sexual assault, fell under the full or partial purview of the military deputy to the USD(P&R).⁹ Although the above is not a comprehensive list of the behaviors most detrimental to the military's well-being and readiness, it encompasses many of the behaviors that DoD perceives as most urgently in need of attention (e.g., sexual assault, suicide, hazing) and some that DoD has been addressing for many years (e.g., unlawful discrimination, sexual harassment, and substance abuse). Furthermore, members of the research community (inside and outside DoD) have identified several of these behaviors as being closely related to one another and have taken steps to integrate their prevention efforts. But we acknowledge that we could have included other behaviors in our study—in particular, family violence, for whose prevention the DASD for Military Community and Family Policy has oversight responsibility.

The six problematic behaviors are defined as shown in the rest of this section. Appendix A presents details on the prevalence of such behaviors in the military.

⁷ The working group proposed an organization headed by a two-star deputy assistant secretary of defense (DASD) for personnel risk with a Senior Executive Service (SES) deputy. Reporting to the DASD would be DSPO, SAPRO, the Operational Safety and Mishap Reduction Program, the Drug Demand Reduction Program (DDRP), the Workplace Safety and Security Office, the Defense Personnel and Security Research Center, and the OSD Privacy Office (Joint Staff High-Risk Behavior Working Group, 2015, pp. 12–13, 24).

⁸ In this report, we use the term *substance-use disorder* to refer to problematic substance use that meets the prior or current *Diagnostic and Statistical Manual of Mental Disorders* (DSM) criteria for a clinical diagnosis. We employ the term *substance misuse* to refer to problematic substance use that does meet DSM criteria, such as binge drinking, heavy drinking, or the nonmedical use of prescription medications. Given that DoD programs target the full range of problematic substance use, we use the term *substance abuse* to encompass both substance misuse and substance-use disorders.

⁹ Much of the military deputy's portfolio of programs addressing problematic behavior was transferred to the new executive director of the Office of Force Resiliency in late 2015.

Sexual Harassment

The legal definition of sexual harassment, codified in DoD Directive (DoDD) 1350.2, specifies that sexual harassment is “a form of sex discrimination that involves unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature.”¹⁰ This definition includes two types of sexual harassment:

- *quid pro quo*, which is “threats to make employment-related decisions (e.g., hiring, promotion, termination) on the basis of target compliance with requests for sexual favors”¹¹
- the creation of a *hostile work environment*, which occurs when the sexual behavior “has the purpose or effect of unreasonably interfering with an individual’s work performance or creates an intimidating, hostile, or offensive working environment.”¹²

This definition is similar to the civilian legal definition codified in 29 C.F.R. § 1604.11, ¶ (a)(3).

Scholars distinguish the legal definition of sexual harassment from other forms of sexual behavior that are harassing but do not occur in work-related settings.¹³ In the civilian literature, there has also been a distinction drawn between sexual harassment as it is legally defined and *psychological sexual harassment*, which is any “unwanted sex-related behavior at work that is appraised by the recipient as offensive, exceeding her resources, or threatening her well-being,” whether illegal or not.¹⁴ That is, a single sexist joke told in a work setting is unlikely to rise to the level of sexual harassment as it is legally defined, but someone in the work setting might nonetheless perceive it as sexual harassment. Conversely, another person who is exposed to pervasive, unwelcome sexual advances might not perceive the experience to be sexual harassment, even though it could meet legal standards. The prevalence estimates of military sexual harassment offered in Appendix A are based on a survey instrument that assessed sexual harassment *as it is legally defined*, regardless of whether the person labeled his or her experiences *sexual harassment*.¹⁵

Sexual Assault

According to DoDD 6495.01, and consistently with Uniform Code of Military Justice Articles 120, 125, and 80,¹⁶ DoD defines sexual assault as intentional sexual contact characterized by use of force, threats, intimidation, or abuse of authority or when the victim does not

¹⁰ USD(P&R), *Department of Defense Military Equal Opportunity (MEO) Program*, Washington, D.C., DoDD 1350.2, August 18, 1995, certified current as of November 21, 2003, incorporating change 2 June 8, 2015, ¶ E2.1.15.

¹¹ Anne M. O’Leary-Kelly, Lynn Bowes-Sperry, Collette Arens Bates, and Emily R. Lean, “Sexual Harassment at Work: A Decade (Plus) of Progress,” *Journal of Management*, Vol. 35, No. 3, June 2009, pp. 503–536, p. 504.

¹² DoDD 1350.2, ¶ E2.1.15.3.

¹³ O’Leary-Kelly et al., 2009.

¹⁴ Louise F. Fitzgerald, Suzanne Swan, and Vicki J. Magley, “But Was It Really Sexual Harassment? Legal, Behavioral, and Psychological Definitions of the Workplace Victimization of Women,” in William T. O’Donohue, ed., *Sexual Harassment: Theory, Research, and Treatment*, Needham Heights, Mass.: Allyn and Bacon, 1997, pp. 5–28, p. 15.

¹⁵ National Defense Research Institute (NDRI), *Sexual Assault and Sexual Harassment in the U.S. Military: Top-Line Estimates for Active-Duty Service Members from the 2014 RAND Military Workplace Study*, Santa Monica, Calif.: RAND Corporation, RR-870-OSD, 2014.

¹⁶ USD(P&R), *Sexual Assault Prevention and Response (SAPR) Program*, Washington, D.C., DoDD 6495.01, January 23, 2012a, incorporating change 2 effective January 30, 2015; DoD, *Uniform Code of Military Justice: Congressional Code of Military Criminal Law Applicable to All Military Members Worldwide*, Washington, D.C., 2000, Subchapter X, Punitive

or cannot consent. Sexual assault includes rape, forcible sodomy (oral or anal sex), and other unwanted sexual contact that is aggravated, abusive, or wrongful; it also includes attempts to commit these acts.

Unlawful Discrimination

DoD policy, codified in DoDD 1350.2, specifies the “right of all service members to serve, advance, and be evaluated based on only individual merit, fitness, capability, and performance” in a military environment that is free of “unlawful discrimination on the basis of race, color, national origin, religion, sex, or sexual orientation,”¹⁷ and DoDD 1020.02E added sexual orientation under the MEO program.¹⁸ In civilian law, Title VII of the Civil Rights Act of 1964 covers discrimination in “hiring, termination, promotion, compensation, job training, or any other term, condition, or privilege of employment.”¹⁹ In addition, although the legal definition considers discrimination in workplaces and educational settings (e.g., biased hiring practices), many researchers study interpersonal discrimination, such as negative acts directed at members of minority groups in nonwork settings.²⁰

Substance Abuse

In the updated fifth edition of the DSM (DSM-5), issued in 2013, changes were implemented in classifying substance-use disorders (SUDs). Prior DSM classifications had separate diagnoses for abuse and dependence to indicate the severity level of the disorder. In the DSM-5, the abuse and dependence classifications were combined into a single designation, SUD. Each specific disorder is separately addressed (e.g., alcohol use disorder, stimulant use disorder), and nearly all use the same overarching criteria to establish a diagnosis. For instance, severity of the disorder is based on the number of symptoms endorsed from a list of 11. Previous criteria related to legal problems have been dropped, and craving has been added to the list of symptoms. One study indicates that the new criteria will not significantly affect the prevalence of SUDs.²¹

Articles, Section 920, Article 120, Rape and Carnal Knowledge; Subchapter X, Punitive Articles, Section 925, Article 125, Forcible Sodomy; Subchapter X, Punitive Articles, Section 880, Article 80, Attempts.

¹⁷ DoDD 1350.2, ¶ E2.1.6, 4.2.

¹⁸ USD(P&R), *Diversity Management and Equal Opportunity in the DoD*, Washington, D.C., DoDD 1020.02E, June 8, 2015.

¹⁹ U.S. Equal Employment Opportunity Commission, “Facts About Race/Color Discrimination,” undated.

²⁰ Enrica N. Ruggs, Larry R. Martinez, and Michelle R. Hebl, “How Individuals and Organizations Can Reduce Interpersonal Discrimination,” *Social and Personality Psychology Compass*, Vol. 5, No. 1, January 2011, pp. 29–42; Devah Pager and Hana Shepherd, “The Sociology of Discrimination: Racial Discrimination in Employment, Housing, Credit, and Consumer Markets,” *Annual Review of Sociology*, Vol. 34, August 2008, pp. 181–209.

²¹ Deborah Hasin and Bari Kilcoyne, “Comorbidity of Psychiatric and Substance Use Disorders in the United States: Current Issues and Findings from the NESARC,” *Current Opinion in Psychiatry*, Vol. 25, No. 3, May 2012, pp. 165–171.

Suicide

To promote the use of consistent terminology, the Centers for Disease Control and Prevention (CDC) put forth standardized definitions for suicide and related behaviors.²² CDC defines suicide as “death caused by self-directed injurious behavior with any intent to die as a result of the behavior.”²³

Hazing

Hazing has received renewed attention in DoD because of alleged hazing incidents that resulted in the deaths of service members and subsequent attention from Congress in the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2013, which requires reports from each of the service secretaries to the House and Senate Armed Services Committees outlining hazing prevention and response efforts.²⁴ In response, DoD revisited its definition of hazing previously established in a 1997 Secretary of Defense memorandum.²⁵

In its updated policy memo, DoD developed a more precise definition that is less subjective in nature:

Hazing is any conduct through which a military member or members, or a Department of Defense civilian employee or employees, without a proper military or other governmental purpose but with a nexus to military service or Department of Defense civilian employment, physically or psychologically injure or create a risk of physical or psychological injury to one or more military members, Department of Defense civilians, or any other persons for the purpose of: initiation into, admission into, affiliation with, change in status or position within, or as a condition for continued membership in any military or Department of Defense civilian organization.²⁶

The policy memo also includes examples of hazing behaviors and distinguishes between hazing and bullying behavior.

Office of the Secretary of Defense and Service Responsibilities for Managing Problematic Behavior

As shown in Figure 1.1, OSD and the services are connected in the effort to deal with the problematic behaviors addressed above. More specifically, OSD and the services take on different—but complementary—missions and roles in tackling problematic behavior. OSD organizations set policies that govern all of DoD. They represent the department in interactions with external organizations, such as in liaisons with the U.S. Department of Veterans Affairs (VA) and

²² Alex E. Crosby, LaVonne Ortega, and Cindi Melanson, *Self-Directed Violence Surveillance: Uniform Definitions and Recommended Data Elements*, version 1.0, Atlanta, Ga.: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, February 2011.

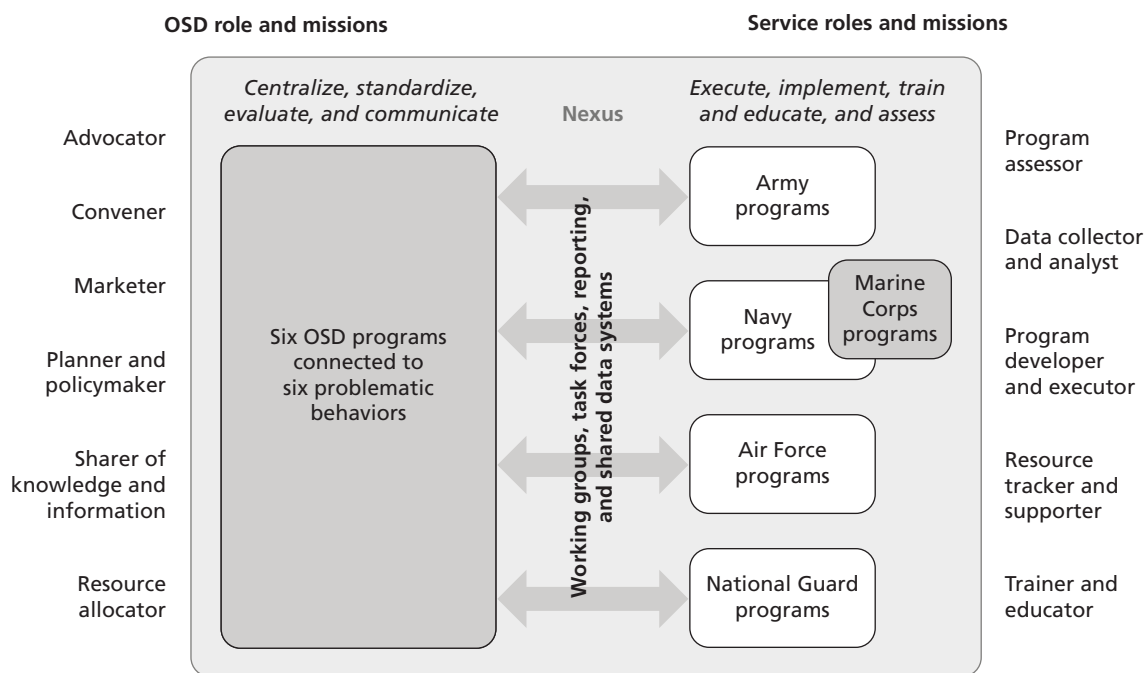
²³ CDC, “Definitions: Self-Directed Violence,” August 28, 2015.

²⁴ Public Law 112-239, National Defense Authorization Act for Fiscal Year 2013, January 2, 2013.

²⁵ William A. Cohen, Secretary of Defense, “Hazing,” memorandum, Washington, D.C.: U.S. Department of Defense, August 28, 1997.

²⁶ Robert O. Work, Deputy Secretary of Defense, “Hazing and Bullying Prevention and Response in the Armed Forces,” memorandum, December 23, 2015.

Figure 1.1
Interconnection Between the Office of the Secretary of Defense and the Services in Dealing with Problematic Behavior



RAND RR1352-1.1

reporting to Congress. They might also have a central role in planning, programming, budgeting, and allocating resources to DoD organizations to execute programs and activities.

Many also perform functions to serve the broad spectrum of DoD organizations involved in addressing a particular problematic behavior. They include sustaining a single DoD-wide data system, setting DoD-wide standards in training and service delivery, developing DoD-wide metrics to assess the effectiveness of programs and initiatives, and creating a DoD-wide campaign message and communication strategy. Finally, OSD-level offices can function as a convener—that is, they can, as directed by the Secretary of Defense and other senior DoD executives, call on DoD organizations to come together to share information, cooperate, and report on their work.

By comparison, service missions and roles are oriented toward implementing programs and initiatives. (Programs can cover active and reserve personnel, including those on joint bases, and Army units and Air Force wings in the National Guard.) Secretaries of the military departments and the service chiefs implement OSD guidance, policies, and procedures by inserting them into service policies and orders and by executing them through their services' programs and activities.

Service headquarter-level organizations are responsible for developing the service-wide guidance, policies, regulations, and, frequently, budgets and manpower estimates. They also develop programs and initiatives for their implementation and are responsible for measuring and reporting their performance and effectiveness to senior service leaders and to OSD organizations, as necessary. Because program implementation typically occurs at the unit command level, service headquarter organizations function as a resource for guidance or expertise; they

also serve as a conduit to convey the concerns and recommendations of unit commanders and local program managers to senior service and OSD leadership.

As shown in the middle of the figure, there is a nexus between OSD and the services. Various mechanisms link OSD and service organizations. Some are defined in policies and directives. Others are determined through consultation. Whether in the form of working groups or a DoD data system that receives submissions from the services, these mechanisms call on organizations involved to work with each other (coordinate) and demonstrate that what they do aligns with DoD policy and supports DoD goals (oversight).

Approach

To develop an integrative framework for preventing and modifying problematic behavior among military personnel, the RAND team focused its research on two major lines of effort (LOEs): behavioral research and programmatic research. The first LOE—behavioral research—starts with the premise mentioned earlier that the behavioral research community inside and outside DoD has made some strides in explaining the connections among problematic behaviors and the premise that such connections between problematic behaviors can have organizational implications. As part of this behavioral research, we sought to answer three questions:

- What are the risk factors associated with problematic behavior?
- What are the recommended methods for preventing problematic behavior?
- How are the above factors and methods similar and different?

To answer those questions, we sought to identify risk factors that were common across the six problematic behaviors selected for examination, as shown above, and then sought to identify effective interventions to prevent each of the six problematic behaviors. To accomplish the former, the team started by conducting a literature review of risk factors within each problematic behavior, used an inductive process to iteratively sort identified risk factors into like categories, culled risk factors that were identified as not relevant to this task (e.g., nonmodifiable factors), and then used the identified categories of shared risk factors to create a conceptual model of the path from an individual's general propensity to engage in problematic behavior to the ultimate selection and enactment of those behaviors.

To accomplish the latter—identifying effective prevention interventions—we conducted a review of meta-analyses and systematic reviews (when available) and the primary academic literature to identify strategies supported by high-quality evidence (i.e., experimental or quasi-experimental trials). Chapters Two and Three present more detail on the approach.

The second LOE—programmatic research—focused on understanding how OSD is organized to deal with selected problematic behaviors, how well is it organized, and what might be alternatives to OSD's current organization. As part of the programmatic research, we sought to answer four questions:

- What OSD organizations are involved in addressing problematic behavior, and how are they structured?
- What coordination and oversight mechanisms are OSD organizations using?

- In terms of their conformity with recognized managerial principles, how well managed are OSD organizations to address problematic behavior?
- What alternatives exist to OSD's current organizational structures that suggest ways in which OSD might improve its oversight and coordination of programs to address problematic behavior?

To answer the first two questions, we primarily used semistructured discussions with officials in OSD offices, programs, centers, and agencies associated with the six problematic behaviors. We also reviewed document sources of information related to OSD's management of efforts to address problematic behavior. To answer the third question, we focused our discussions and document reviews on OSD organizations that address problematic behavior and consulted the business management literature for best practices in organizational integration.

To answer the fourth question, we relied on the organizational design literature and the services for alternatives to OSD-level structures. We collected information on service structures through semistructured discussions with officials in the Army, Air Force, Navy, and Marine Corps responsible for managing programs that address problematic behavior, as well as by reviewing documents on these programs that were publicly available or provided to us by those with whom we spoke.

Chapters Four and Five provide more detail on the approaches used for the OSD- and service-related programmatic research, respectively.

Finally, drawing on the results of the behavioral and programmatic research, our concluding chapter attempts to provide answers to the following two questions:

- To what extent should programs to address problematic behavior be integrated?
- If they are integrated, in what ways should that occur?

Caveat

Before turning to our recommendations, we provide the following caveat with respect to our programmatic findings. Information in this report reflects organizational arrangements within OSD as of the end of October 2015, when we completed our data collection, analysis, and writing. Subsequent to that date, reorganization has occurred, and new positions have been created, such as changes in the military deputy's portfolio and the establishment of an executive director of the Office of Force Resiliency in the Office of the USD(P&R). Nevertheless, even as changes occur in OSD's organizational structure, we believe that the information and analysis in this report provide a foundational understanding of OSD's management of problematic behavior, the major issues and challenges OSD faces, and OSD's goals for addressing problematic behavior.

Organization of This Document

The preceding list of research questions provides the basic structure for the remainder of this report. Chapters Two and Three provide answers to the initial three behavioral research questions, broken across identifying risk factors common across the six problematic behaviors (Chapter Two) and identifying effective interventions to prevent each of the six problematic behaviors (Chapter Three). Chapter Four addresses the first three programmatic research questions

about organizations that address problematic behavior and their oversight and coordination mechanisms and management practices within the context of OSD. Chapter Five addresses the fourth programmatic question on the structural alternatives to OSD organizations that address problematic behavior. Drawing on our behavioral and programmatic research, Chapter Six focuses on the final two integrative questions and provides conclusions and associated recommendations intended to help improve OSD's oversight and coordination of problematic-behavior efforts affecting military personnel.

Appendix A presents prevalence figures in the military for the six problematic behaviors discussed in this report. Appendix B presents the protocol we used for our policy discussions with OSD and service headquarters officials. Appendix C captures more-detailed discussions of the service programs to address the problematic behaviors reviewed as part of the study.

Identifying Common Risk Factors Across the Six Problematic Behaviors

As discussed in Chapter One, the study's goal was to help ensure that OSD's programs for addressing problematic behavior among military personnel are appropriately integrated. Traditionally, DoD has focused its attention on specific problematic behavior in response to congressional, media, and public demands to respond to notable events, such as a spike in the number of sexual assaults or suicide deaths. Although this approach has begun to change, currently only limited research empirically demonstrates the interrelationships among problematic behaviors or the pros and cons of integrating planning and programming to address problematic behavior.

This chapter presents the results of a literature review intended to identify common risk factors; Chapter Three provides the results of a literature review identifying effective prevention strategies. The goal of both chapters is to contribute to the development of a scientific rationale for program integration within OSD.

Methods

To identify risk factors common across more than one problematic behavior, we first conducted a literature review of risk factors for each problematic behavior. We focused only on well-established risk factors for which there was general scientific consensus about their relationship with a given problematic behavior. Given our focus on those risk factors with only the highest level of research support, we focused our literature review on published meta-analyses¹ and systematic reviews. Each risk factor reviewed here has a rigorously established relationship with the problematic behavior, either through a meta-analysis or through multiple experimental or correlational studies.

Second, we used an inductive process to iteratively sort identified risk factors (across all problematic behaviors) into like categories (e.g., social skill deficits). We continued the sorting process until all researchers on the project team were satisfied with the identified categories.

Third, we culled risk factors that were not relevant to the task. Culled risk factors included identified correlates that are not modifiable in an adult population and that should not be used to screen out otherwise-qualified applicants (e.g., age, race and ethnicity, childhood trauma). However, some of these factors could be used to select people for inclusion in a prevention program (e.g., delivering a prevention program to younger service members who are at higher risk than older service members for engaging in some problematic behavior). Given the goal of

¹ Meta-analysis is a statistical technique used to combine the findings from multiple studies.

identifying risk factors common across more than one problematic behavior, we also removed any risk-factor category that was not present across more than one behavior.

Finally, we used the identified categories of shared risk factors to create a conceptual model of the path from an individual's general propensity to engage in problematic behavior to the ultimate selection and enactment of these behaviors. We use this model to highlight different stages that lead to problematic behavior, each of which provides a moment of opportunity to intervene and potentially prevent the problematic behavior from emerging.²

Our selected review method has strengths and weaknesses. For this task, our focus on well-established risk factors provides certainty to leaders and decisionmakers that the identified correlates are indeed related to problematic behavior and potentially fruitful targets for prevention efforts. However, those risk factors not included in the current review—either because they have not been studied or because adequate empirical evidence has not yet accumulated—are not necessarily poor targets. We simply cannot be certain, at the current date, of their relationship with multiple problematic behaviors. Another potential weakness of our conceptual model is that it does not allow for interaction effects across risk factors, especially ones that we have excluded from our analysis. Finally, although we believe that a summary of those shared, rigorously supported risk factors provides an important perspective, it is also important for policymakers to maintain visibility on other perspectives, including theoretical models of problematic behaviors and emerging evidence of risk factors that has not yet been widely replicated.

Developing the Conceptual Model and Common Risk Factors

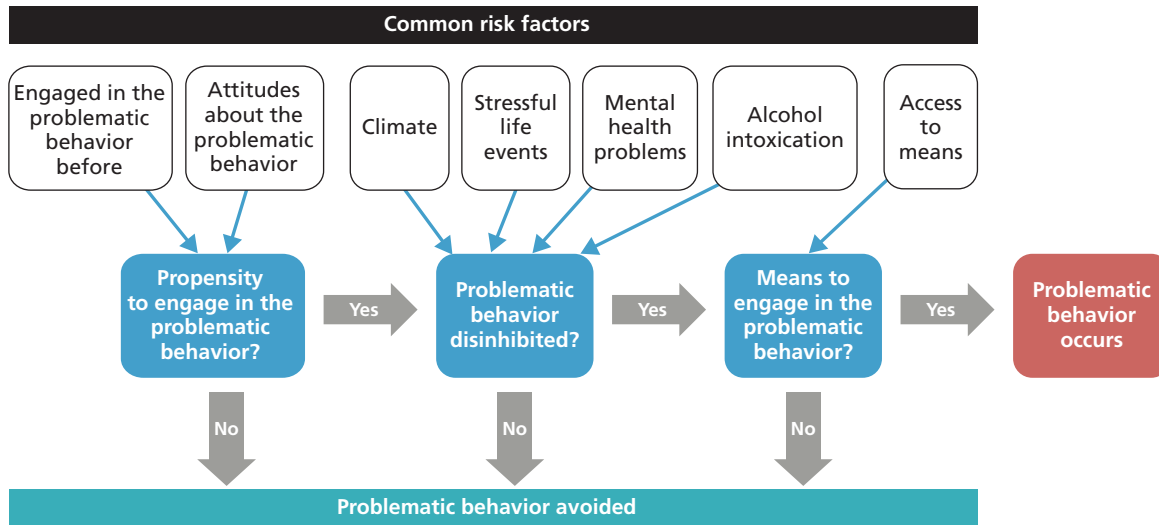
As discussed above, the final step in the literature review process was developing a conceptual model as a way of identifying shared risk factors. As shown in Figure 2.1, the model describes risk in the three primary stages. The first stage assesses *the individual's propensity to engage in these behaviors*. For genetic, personality, or environmental reasons, some individuals might be entirely disinclined to pursue problematic behavior. These individuals drop into the “problematic behavior avoided” category.” However, those who do have a propensity to engage in problematic behavior do not necessarily go on to do so because there are subsequent steps at which the problematic behavior can be avoided.

The second stage assesses whether *the problematic behavior is disinhibited*. For many people who might be inclined to engage in problematic behavior, social, occupational, legal, or personal constraints can prevent them from pursuing these behaviors. When these constraints successfully prevent the individual from engaging in the otherwise-preferred behavior, the problematic behavior is avoided. For example, according to Ajzen and Fishbein's theory of reasoned action, attitudes are most predictive of behaviors when the situation supports the attitude–behavior connection.³ When an attitude predisposes someone to perform a problematic behavior, situations that support the behavior make it more likely to occur (i.e., disinhibit

² A conceptual model is used to illustrate an idea about how events might occur. Unlike a mathematical or statistical model, the precise numerical relationships and complex interactions between model elements are not usually specified. However, conceptual models can be and often are used to inform future statistical models that specify and test a more complete set of relationships.

³ Icek Ajzen and Martin Fishbein, “Attitude–Behavior Relations: A Theoretical Analysis and Review of Empirical Research,” *Psychological Bulletin*, Vol. 84, No. 5, September 1977, pp. 888–918.

Figure 2.1
Conceptual Model Describing a Common Process Leading to Problematic Behavior



RAND RR1352-2.1

the behavior), while situations that do not support the attitude–behavior connection inhibit the problematic behavior.

The third stage assesses whether *the disinhibited individual has the means to act on his or her preferences to engage in the problematic behavior*. If the individual lacks access to the means necessary to engage in the problematic behavior, the behavior is avoided. However, an individual with the propensity to engage in the behavior, who is disinhibited, and who has the means is very likely to engage in the problematic behavior. For example, someone with gender or racial biases cannot act on these biases to commit employment discrimination until he or she has the means to do so (i.e., a leadership role with the power to make hiring and other employment-related decisions). Someone with the desire to die by suicide is less likely to do so if he or she lacks access to the means to do so (e.g., firearms have been removed from his or her home).⁴

Although the model is conceptualized as having three necessary stages, there might be some exceptions in which individuals who do not have a general propensity to engage in a behavior nonetheless do so. For example, in a group setting in which social norms and pressure to engage in a behavior are very strong, an otherwise-disinclined individual might engage in a problematic behavior. Individuals would, however, still need access to the means to perform the behavior before the behavior could occur.

As shown in the figure, we identified seven shared risk factors across two or more problematic behaviors. Two risk factors described a general propensity to engage in a problematic behavior:

- history of engaging in the problematic behavior
- attitudes that are positive toward or sanction the problematic behavior.

⁴ Rajeev Ramchand, Joie Acosta, Rachel M. Burns, Lisa H. Jaycox, and Christopher G. Pernin, *The War Within: Preventing Suicide in the U.S. Military*, Santa Monica, Calif.: RAND Corporation, MG-953-OSD, 2011.

Four risk factors can be described as elements that serve to *disinhibit (or allow)* the problematic behavior:

- a social climate that sanctions the problematic behavior
- stressful life events
- mental health problems
- acute alcohol intoxication.

For example, someone who had avoided perpetrating sexual harassment in a work setting with a strong culture of respect might go on to commit sexual harassment when transferred to a work setting with a climate that tolerates sexual talk and behavior in the workplace. Alternatively, someone with suicidal thoughts who had been previously constrained from acting on those thoughts might make a suicide attempt when disinhibited because of acute alcohol intoxication. Finally, we identified access to the means to engage in the problematic behavior (e.g., a firearm with respect to suicide) as a risk factor. We discuss each of the seven risk factors below.

Propensity to Engage

Propensity to engage includes two shared risk factors in our model.

Engaged in the Behavior Before

The first risk factor is having engaged in the behavior before. Across behaviors, one of the best predictors of whether someone will do something in the future is whether the person has done so previously. We found evidence that past behavior predicted future behavior for sexual assault, substance abuse, and suicide. For example, there is evidence that someone with a history of committing sexual assault is more likely to do so in the future;⁵ early-onset substance use is considered a predictor of young-adult alcohol and substance dependence,⁶ and previous suicide attempts are a risk factor for future attempts.⁷

Attitudes Toward Problematic Behavior

Thoughts and feelings that predispose someone to perform a behavior are also risk factors for multiple problematic behaviors. For instance, prejudicial attitudes about groups of people are associated with discriminating against them,⁸ and individuals who have negative attitudes toward women who take on traditionally male roles might be more likely to engage in sexual harassment.⁹ We identified attitudes that are positive toward or sanction a given problematic

⁵ Stephanie K. McWhorter, Valerie A. Stander, Lex L. Merrill, Cynthia J. Thomsen, and Joel S. Milner, "Reports of Rape Reperpetration by Newly Enlisted Male Navy Personnel," *Violence and Victims*, Vol. 24, No. 2, 2009, pp. 204–218.

⁶ K. M. King and L. Chassin, "A Prospective Study of the Effects of Age of Initiation of Alcohol and Drug Use on Young Adult Substance Dependence," *Journal of Studies on Alcohol and Drugs*, Vol. 68, No. 2, March 2007, pp. 256–265.

⁷ U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*, Washington, D.C., September 2012.

⁸ John F. Dovidio and Samuel L. Gaertner, "Affirmative Action, Unintentional Racial Biases, and Intergroup Relations," *Journal of Social Issues*, Vol. 52, No. 4, Winter 1996, pp. 51–75.

⁹ Denise M. Driscoll, Janice R. Kelly, and Wendy L. Henderson, "Can Perceivers Identify Likelihood to Sexually Harass?" *Sex Roles*, Vol. 38, No. 7, April 1998, pp. 557–588.

behavior as risk factors for sexual harassment, sexual assault, discrimination, and substance abuse.

Problematic Behavior Disinhibited

The second component of our model, disinhibition of the problematic behavior, is associated with four shared risk factors.

Climate

We defined climate as the interpretations of traditions, culture, and social norms that define what behaviors are appropriate or inappropriate for the group.¹⁰ Climate also involves the unwritten rules of a group that outline the behaviors in which a group member might feel the need to participate so that the member fits in with similar others, such as those in the member's unit, service branch, barracks, or social group. For example, groups that have social norms of fairness and equality are less likely to discriminate,¹¹ and sexual harassment is less frequent in military groups in which leadership is perceived as less tolerant of the behavior.¹² We identified climate as a risk factor for sexual harassment, sexual assault, discrimination, substance abuse, and suicide.

Stressful Life Events

We also identified stressful life events as a shared risk factor for problematic behavior. Stressful life events are occurrences that cause severe strain and readjustment, such as financial or occupational pressure, legal problems, interpersonal conflicts, loss, or victimization. We identified stressful life events as a risk factor for substance abuse and suicide. For example, concern about family finances is associated with problem drinking among military personnel.¹³

Mental Health Problems

In accordance with DSM-5, we defined a *mental health problem* as a clinically significant disturbance in cognition, emotional regulation, or behavior reflecting a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.¹⁴ Mental health problems can include posttraumatic stress disorder (PTSD) and major depressive disorder.

¹⁰ For specialists in workplace behavior, *climate* is a narrow term that refers specifically to shared worker perceptions and interpretations of workplace policy, practices, and procedures (Benjamin Schneider, Mark G. Ehrhart, and William H. Macey, "Organizational Climate and Culture," *Annual Review of Psychology*, Vol. 64, 2013, pp. 361–388). This definition diverges from the more general usage we employ here.

¹¹ Jolanda Jetten, Russell Spears, and Antony S. R. Manstead, "Distinctiveness Threat and Prototypicality: Combined Effects on Intergroup Discrimination and Collective Self-Esteem," *European Journal of Social Psychology*, Vol. 27, 1997, pp. 635–657.

¹² Louise F. Fitzgerald, Fritz Drasgow, and Vicki J. Magley, "Sexual Harassment in the Armed Forces: A Test of an Integrated Model," *Military Psychology*, Vol. 11, No. 3, 1999, pp. 329–343.

¹³ Heather M. Foran, Amy M. Smith Slep, and Richard E. Heyman, "Hazardous Alcohol Use Among Active Duty Air Force Personnel: Identifying Unique Risk and Promotive Factors," *Psychology of Addictive Behaviors*, Vol. 25, No. 1, March 2011, pp. 28–40.

¹⁴ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed., Washington, D.C., 2013.

der (MDD) and are a risk factor for substance abuse and suicide. For example, anxiety disorders, largely PTSD, have been linked to alcohol abuse in service members.¹⁵

Alcohol Intoxication

Alcohol intoxication is defined as alcohol consumption resulting in impaired judgment, memory, concentration, and perception, as well as reduced inhibitions. Our review identified alcohol intoxication as a risk factor for sexual assault and suicide. Perpetrators use alcohol in 50 to 70 percent of sexual assault incidents,¹⁶ and alcohol intoxication can be a risk factor for suicidal ideation.¹⁷

Access to Means

Finally, risk for engaging in problematic behavior increases when someone has the means available to carry out these behaviors. We identified strong evidence to support access as a risk factor for sexual assault, discrimination, substance abuse, and suicide. For example, easy access to lethal means (e.g., firearms) contributes to the likelihood of completed suicide,¹⁸ and higher alcohol-outlet density in a close radius of college campuses is correlated with the frequency of drunkenness.¹⁹

The section that follows describes risk factors for each behavior in more detail.

Assessing Problematic Behavior in Terms of Common Risk Factors

The amount and quality of literature investigating risk factors varies depending on the behavior, but all risk factors described here had strong, consistent evidence to support their association with two or more problematic behaviors. Of the selected problematic behaviors, four focus on behaviors perpetrated against others (i.e., sexual harassment, sexual assault, discrimination, and hazing) and two focus on behaviors directed at oneself (i.e., substance abuse and suicide). Some behaviors have more than a century of research devoted to understanding their etiology (e.g., discrimination, suicide), while the research literature exploring other behaviors is relatively sparse (e.g., hazing, sexual harassment). In addition, the risk factors that have been investigated are subject to disciplinary customs and trends. For example, discrimination has been studied mainly by social scientists, so most of the risk factors explored for this behavior

¹⁵ Institute of Medicine (IOM), Committee on Prevention, Diagnosis, Treatment and Management of Substance Use Disorders in the U.S. Armed Forces, Board on the Health of Select Populations, *Substance Use Disorders in the U.S. Armed Forces*, Washington, D.C., 2013.

¹⁶ Leanne R. Brecklin and Sarah E. Ullman, "The Roles of Victim and Offender Alcohol Use in Sexual Assaults: Results from the National Violence Against Women Survey," *Journal of Studies on Alcohol*, Vol. 63, No. 1, January 2002, pp. 57–63; Patricia Tjaden and Nancy Thoennes, *Extent, Nature, and Consequences of Rape Victimization: Findings from the National Violence Against Women Survey*, Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, NCJ 210346, January 2006.

¹⁷ Laura Aiuppa Denning, Marc Meisnere, and Kenneth E. Warner, eds., *Preventing Psychological Disorders in Service Members and Their Families: An Assessment of Programs*, Washington, D.C.: National Academies Press, 2014.

¹⁸ U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012.

¹⁹ Richard Scribner, Karen Mason, Katherine Theall, Neal Simonsen, Shari Kessel Schneider, Laura Gomberg Towvim, and William DeJong, "The Contextual Role of Alcohol Outlet Density in College Drinking," *Journal of Studies on Alcohol and Drugs*, Vol. 69, No. 1, 2008, pp. 112–120.

have been psychological (e.g., attitudes) or social (e.g., group processes) in nature. In contrast, clinical psychologists and medical researchers have studied substance abuse, so the risk factors identified for this behavior are more clinical in nature (e.g., mental health correlates). Thus, it is important to note that the specific risk factors associated with the problematic behaviors noted below do not make up a complete list of all possible risk factors; relationships can exist between risk factors and behaviors that have yet to be fully explored.

Table 2.1 summarizes the results of our literature review about the risk factors associated with the six behaviors we examined. An *x* indicates that there is substantial empirical evidence (either a meta-analysis or multiple experimental or correlational studies) for a relationship between the risk factor and the problematic behavior. Although the specific risk factors varied across behaviors, three risk factor categories emerged as the most common: attitudes about the behavior, climate, and access to the means to engage in the behavior. Attitudes that are positive toward or sanction problematic behavior are risk factors for sexual harassment, sexual assault, discrimination, and substance abuse. Access to the means to engage in the behavior emerged as a shared risk factor for sexual assault, discrimination, substance abuse, and suicide. There was strong empirical evidence that climate is a risk factor for all behaviors except hazing. These factors fit into the three stages of our conceptual model—propensity to engage, problematic behavior disinhibited, and access to means—and are suggestive of potential shared risk factors across behaviors. The details underlying the table are discussed below, working down the columns of problematic behaviors.

Table 2.1
Cross Between Problematic Behaviors and Risk Factors

| Risk Factor | Sexual Harassment | Sexual Assault | Unlawful Discrimination | Substance Abuse | Suicide | Hazing |
|--|-------------------|----------------|-------------------------|-----------------|---------|--------|
| Propensity to engage in behavior | | | | | | |
| Engaged in behavior before | | x | | x | x | |
| Attitudes about behavior | x | x | x | x | | |
| Problematic behavior disinhibited | | | | | | |
| Climate | x | x | x | x | x | |
| Stressful life events | | | | x | x | |
| Mental health problem | | | | x | x | |
| Alcohol intoxication | | x | | | x | |
| Access to engage in problematic behavior | | | | | | |
| Access to means | | x | x | x | x | |

NOTE: An *x* indicates that there is substantial empirical evidence (either a meta-analysis or multiple experimental or correlational studies) for a relationship between the risk factor and the problematic behavior. Although the hazing literature does not include sufficient empirical evidence of risk factors to warrant its inclusion in this table, we discuss theoretical linkages between hazing and various risk factors later in this chapter.

Risk Factors Associated with Sexual Harassment

Research on the factors associated with actual sexual harassment behavior in the workplace is sparse, mostly because it is difficult to accurately measure people's engagement in sexual harassment in real-world situations. Research participants are reluctant to admit to sexually harassing coworkers.²⁰ We know more about sexual harassment's effect on victims, but this research does not tell us what factors cause the harasser to commit the behavior. Therefore, researchers have studied this behavior using either surveys assessing proxies of sexual harassment (e.g., tolerance of sexual harassment in the workplace) or laboratory experiments with behaviors suggestive of workplace sexual harassment (e.g., sending a pornographic image to a research confederate). Furthermore, most research on this topic has considered male harassment of female coworkers and might not be relevant to female-to-male or same-sex sexual harassment. Thus, although there is a substantial body of research on sexual harassment, measurement issues limit our knowledge of the risk factors associated with perpetrating sexual harassment.

Engaged in Behavior Before

There are strong theoretical reasons to believe that people who have engaged in sexual harassment before are more likely than others to continue to engage in sexual harassment in the future. But there is limited empirical evidence for this phenomenon. As noted above, people's engagement in sexual harassment is difficult to measure accurately in organizations. Thus, research on perpetrators of sexual harassment is unlikely to accurately measure the connection between past and current sexual harassment behavior. However, there are other reasons to believe that people who have engaged in sexual harassment before are more likely than others to do so in the future. For example, the attitudes and personality traits associated with sexual harassment are relatively stable over time.²¹

Attitudes About Behavior

Several studies have demonstrated that negative attitudes toward women are associated with tolerance of sexual harassment. This is particularly true of attitudes toward women's roles in male-dominated organizations. Researchers have focused on two aspects of attitudes toward women: hostile sexism and attitudes favoring traditional male–female sex roles. Hostile sexism is defined as general antipathy toward women,²² and “men who endorse hostile sexism direct hostility toward non-traditional or ‘bad’ women” who are perceived to be taking power from men.²³ Research demonstrates that men who have hostile attitudes toward women are more

²⁰ O'Leary-Kelly et al., 2009.

²¹ Brenda L. Russell and Kristin Y. Trigg, “Tolerance of Sexual Harassment: An Examination of Gender Differences, Ambivalent Sexism, Social Dominance, and Gender Roles,” *Sex Roles*, Vol. 50, No. 7, April 2004, pp. 565–573.

²² Peter Glick and Susan T. Fiske, “The Ambivalent Sexism Inventory: Differentiating Hostile and Benevolent Sexism,” *Journal of Personality and Social Psychology*, Vol. 70, No. 3, March 1996, pp. 491–512.

²³ Cinnamon L. Danube, Theresa K. Vescio, and Kelly Cue Davis, “Male Role Norm Endorsement and Sexism Predict Heterosexual College Men's Attitudes Toward Casual Sex, Intoxicated Sexual Contact, and Casual Sex [sic],” *Sex Roles*, Vol. 71, No. 5, October 2014, pp. 219–232, p. 221.

tolerant than others of sexual harassment in the workplace²⁴ and are more likely to sexually harass women in laboratory situations.²⁵

Climate

Climate can encourage or discourage sexually harassing behaviors among group members. Many studies show that perceived organizational tolerance of sexual harassment is associated with reports of sexually harassing behaviors.²⁶ Perceived organizational tolerance of sexual harassment is defined as a worker's beliefs about how seriously the employing organization takes complaints about sexual harassment and how likely the worker thinks the organization is to take action to correct sexual harassment.²⁷ A meta-analysis of 41 studies examining the relationship between perceived organizational tolerance of sexual harassment and sexually harassing behaviors also found evidence that perceived tolerance is strongly related to sexual harassment.²⁸ Also, research on military contexts shows that perceptions of leadership tolerance of sexual harassment are associated with increased perceptions of sexual harassment occurring in the workplace.²⁹

Similarly, the meta-analysis also found that organizations with disproportionately fewer women have higher rates of sexual harassment.³⁰ This relationship has been replicated in studies of military groups.³¹ The proportion of women in an organization or work group is an indication of the workplace gender context, which encompasses the "factors that constitute the gendered nature of the individual's work group."³² However, the meta-analysis also showed that the relationships between sexual harassment and perceived organizational tolerance of sexual harassment, on the one hand, and group gender proportions, on the other, were significantly stronger among civilian than military samples.³³ This suggests that, although military organizational context is an important predictor of sexual harassment behavior, it might not be as closely tied to reports of sexual harassment as it is in civilian organizations. Or it might be

²⁴ Joseph J. Begany and Michael A. Milburn, "Psychological Predictors of Sexual Harassment: Authoritarianism, Hostile Sexism, and Rape Myths," *Psychology of Men and Masculinity*, Vol. 3, No. 2, July 2002, pp. 119–126; Richard L. Wiener, Linda Hurt, Brenda Russell, Kelley Mannen, and Charles Gasper, "Perceptions of Sexual Harassment: The Effects of Gender, Legal Standard, and Ambivalent Sexism," *Law and Human Behavior*, Vol. 21, No. 1, February 1997, pp. 71–93; Russell and Trigg, 2004.

²⁵ Charlotte Diehl, Jonas Rees, and Gerd Bohner, "Flirting with Disaster: Short-Term Mating Orientation and Hostile Sexism Predict Different Types of Sexual Harassment," *Aggressive Behavior*, Vol. 38, No. 6, November–December 2012, pp. 521–531; Frank Siebler, Saskia Sabelus, and Gerd Bohner, "A Refined Computer Harassment Paradigm: Validation, and Test of Hypotheses About Target Characteristics," *Psychology of Women Quarterly*, Vol. 32, No. 1, March 2008, pp. 22–35.

²⁶ O'Leary-Kelly et al., 2009.

²⁷ Marita P. McCabe and Lisa Hardman, "Attitudes and Perceptions of Workers to Sexual Harassment," *Journal of Social Psychology*, Vol. 145, No. 6, 2005, pp. 719–740.

²⁸ Chelsea R. Willness, Piers Steel, and Kibeom Lee, "A Meta-Analysis of the Antecedents and Consequences of Workplace Sexual Harassment," *Personnel Psychology*, Vol. 60, No. 1, Spring 2007, pp. 127–162.

²⁹ Fitzgerald, Drasgow, and Magley, 1999.

³⁰ Willness, Steel, and Lee, 2007.

³¹ Fitzgerald, Drasgow, and Magley, 1999.

³² Louise F. Fitzgerald, Suzanne Swan, and Karla Fischer, "Why Didn't She Just Report Him? The Psychological and Legal Implications of Women's Responses to Sexual Harassment," *Journal of Social Issues*, Vol. 51, No. 1, Spring 1995, pp. 117–138, p. 62.

³³ Willness, Steel, and Lee, 2007.

that the restriction in range of gender balances within military organizations limits statistical power to detect this effect.

Recent research has found that the association between organizational context and sexual harassment is stronger in men who have negative or hostile attitudes toward women. One study found that men's perceptions of organizational justice (e.g., that women and men are treated equally in the organization) was a stronger predictor of sexually harassing proclivities among men high in hostile sexism than among men low in hostile sexism.³⁴

Stressful Life Events, Mental Health Problems, and Alcohol Intoxication

We did not find evidence of a strong, consistent empirical relationship between these risk factors and sexual harassment.

Access to Means

There is some evidence that access to the means necessary to commit sexual harassment is associated with engaging in the behavior, but the nature of the relationship is complicated. The main evidence for the connection is that supervisors are more likely than coworkers to be reported as perpetrators of sexual harassment.³⁵ However, other research has demonstrated that the harasser's perception of the harasser's own power is a stronger predictor of sexual harassment than being in an actual position of power is.³⁶ Furthermore, the extent to which men view women as threatening their social status is a potent predictor of sexual harassment against women.³⁷ Indeed, there is some evidence that sexual harassment is not necessarily provoked by sexual desire but that women in male-dominated groups who are viewed as having more "masculine" traits (e.g., they are seen as assertive, dominant, and independent) experience the most sexual harassment.³⁸ Thus, men's perceptions of their power and the threat they feel that women pose to their power are the clearest predictors of sexual harassment.

Risk Factors Associated with Sexual Assault

The review that follows focuses primarily on sexual assault perpetrated by men against women. This type of assault has been the focus of most of the sexual assault literature, but it represents a limitation when generalized to military sexual assault, in which more than half the victims are men who typically have been assaulted by male assailants.³⁹ It is currently unknown whether the risk factors that follow are also strong predictors of sexual assaults perpetrated by men against men.

³⁴ Franciska Krings and Stéphanie Facchin, "Organizational Justice and Men's Likelihood to Sexually Harass: The Moderating Role of Sexism and Personality," *Journal of Applied Psychology*, Vol. 94, No. 2, March 2009, pp. 501–510.

³⁵ O'Leary-Kelly et al., 2009.

³⁶ O'Leary-Kelly et al., 2009.

³⁷ Elena Dall'Ara and Anne Maass, "Studying Sexual Harassment in the Laboratory: Are Egalitarian Women at Higher Risk?" *Sex Roles*, Vol. 41, No. 9, November 1999, pp. 681–704; Anne Maass, Mara Cadinu, Gaia Guarnieri, and Annalisa Grasselli, "Sexual Harassment Under Social Identity Threat: The Computer Harassment Paradigm," *Journal of Personality and Social Psychology*, Vol. 85, No. 5, November 2003, pp. 853–870.

³⁸ Jennifer L. Berdahl, "The Sexual Harassment of Uppity Women," *Journal of Applied Psychology*, Vol. 92, No. 2, 2007, pp. 425–437.

³⁹ NDRI, 2014.

Engaged in Behavior Before

One of the best predictors of whether someone is likely to perpetrate a sexual assault in the future is whether that person has already sexually assaulted someone in the past.⁴⁰ For example, a methodologically rigorous longitudinal study showed that college men with histories of sexual assault perpetration were nine times more likely to commit another sexual assault in the next semester of college than young men without histories of sexual violence were.⁴¹ White and Smith, 2004, documents a three- to elevenfold increase in the likelihood of perpetrating a sexual assault based on whether the individual had sexually assaulted someone during the previous year of college.⁴² Similar data are available from a military cohort of 2,925 male Navy recruits who were studied as they transitioned from civilian status through the second year of service.⁴³ Thirteen percent of recruits self-reported that they had attempted or completed a rape by the end of the first year of service, and, of these Navy men with history of sexual violence, 71 percent perpetrated during the second year of service.⁴⁴ Comparable data for the remaining service branches have not been published.

Attitudes About Behavior

The most common measure of attitudes toward sexual violence is the Rape Myth Acceptance scale.⁴⁵ This scale, and its variants, includes statements that justify sexual assault, and respondents indicate how much they agree with each statement.⁴⁶ Example statements include the following: “Men don’t usually intend to force sex on a woman, but sometimes they get too sexually carried away” and “When a woman is raped, she usually did something careless to put herself in that situation.” All statements are designed to measure the respondent’s sense that rape is justifiable in some situations or beliefs that shift responsibility for the assault from

⁴⁰ Christine A. Gidycz, Jennifer B. Warkentin, and Lindsay M. Orchowski, “Predictors of Perpetration of Verbal, Physical, and Sexual Violence: A Prospective Analysis of College Men,” *Psychology of Men and Masculinity*, Vol. 8, No. 2, April 2007, pp. 79–94; Catherine Loh and Christine A. Gidycz, “A Prospective Analysis of the Relationship Between Childhood Sexual Victimization and Perpetration of Dating Violence and Sexual Assault in Adulthood,” *Journal of Interpersonal Violence*, Vol. 21, No. 6, June 2006, pp. 732–749; Catherine Loh, Christine A. Gidycz, Tracy R. Lobo, and Rohini Luthra, “A Prospective Analysis of Sexual Assault Perpetration: Risk Factors Related to Perpetrator Characteristics,” *Journal of Interpersonal Violence*, Vol. 20, No. 10, October 2005, pp. 1325–1348; Neil M. Malamuth, Daniel Linz, Christopher L. Heavey, Gordon Barnes, and Michele Acker, “Using the Confluence Model of Sexual Aggression to Predict Men’s Conflict with Women: A 10-Year Follow-Up Study,” *Journal of Personality and Social Psychology*, Vol. 69, No. 2, August 1995, pp. 353–369; Jacquelyn W. White and Paige Hall Smith, “Sexual Assault Perpetration and Reperpetration: From Adolescence to Young Adulthood,” *Criminal Justice and Behavior*, Vol. 31, No. 2, April 2004, pp. 182–202.

⁴¹ Loh and Gidycz, 2006.

⁴² White and Smith, 2004.

⁴³ McWhorter et al., 2009.

⁴⁴ McWhorter et al., 2009.

⁴⁵ Martha R. Burt, “Cultural Myths and Supports for Rape,” *Journal of Personality and Social Psychology*, Vol. 38, No. 2, February 1980, pp. 217–230.

⁴⁶ Burt, 1980; Diana L. Payne, Kimberly A. Lonsway, and Louise F. Fitzgerald, “Rape Myth Acceptance: Exploration of Its Structure and Its Measurement Using the Illinois Rape Myth Acceptance Scale,” *Journal of Research in Personality*, Vol. 33, No. 1, March 1999, pp. 27–68.

the perpetrator to the victim.⁴⁷ The scale has been scientifically validated.⁴⁸ A broad research literature demonstrates that endorsing attitudes that justify or excuse rape predicts risk for perpetrating a sexual assault. A recent systematic review published in 2013 identified 24 studies that had demonstrated that these attitudes predict perpetration of sexual violence both cross-sectionally and longitudinally.⁴⁹ Similarly, a meta-analysis reported “a large positive overall effect size” when summarizing the results of multiple studies that established a relationship between endorsing rape myths and perpetrating sexual assault.⁵⁰

Climate

Evidence from multiple sources suggests that young adult men who belong to social groups that support and excuse sexual violence are more likely than others to be sexually aggressive themselves.⁵¹ For both community and college men, there is a positive association between perceiving one’s male peers as supporting sexual violence and committing a sexual assault oneself.⁵² Findings are also generally supportive, though mixed, that belonging to exclusively male social groups, such as fraternities and athletic teams, is associated with an increased likelihood of committing a sexual assault.⁵³ However, some studies that have examined these relationships in detail have found that other correlated factors, such as the intensity of alcohol use⁵⁴ or group sponsorship of parties that were “conducive to sexual offenses,”⁵⁵ explain most of the relationship between membership in male-dominated groups and sexual assaults.

⁴⁷ Kimberly A. Lonsway and Louise F. Fitzgerald, “Attitudinal Antecedents of Rape Myth Acceptance: A Theoretical and Empirical Reexamination,” *Journal of Personality and Social Psychology*, Vol. 68, No. 4, April 1995, pp. 704–711.

⁴⁸ Burt, 1980; Payne, Lonsway, and Fitzgerald, 1999; Eliana Suarez and Tahany M. Gadalla, “Stop Blaming the Victim: A Meta-Analysis on Rape Myths,” *Journal of Interpersonal Violence*, Vol. 25, No. 11, November 2010, pp. 2010–2035.

⁴⁹ Andra Teten Tharp, Sarah DeGue, Linda Anne Valle, Kathryn A. Brookmeyer, Greta M. Massetti, and Jennifer L. Matjasko, “A Systematic Qualitative Review of Risk and Protective Factors for Sexual Violence Perpetration,” *Trauma, Violence, and Abuse*, Vol. 14, No. 2, 2013, pp. 133–167.

⁵⁰ Suarez and Gadalla, 2010, p. 2023.

⁵¹ Tharp et al., 2013.

⁵² Antonia Abbey, Michele R. Parkhill, A. Monique Clinton-Sherrod, and Tina Zawacki, “A Comparison of Men Who Committed Different Types of Sexual Assault in a Community Sample,” *Journal of Interpersonal Violence*, Vol. 22, No. 12, December 2007, pp. 1567–1580; F. Scott Christopher, Mary Madura, and Lori Weaver, “Premarital Sexual Aggressors: A Multivariate Analysis of Social, Relational, and Individual Variables,” *Journal of Marriage and the Family*, Vol. 60, No. 1, February 1998, pp. 56–69; Walter S. DeKeseredy and Katharine Kelly, “Sexual Abuse in Canadian University and College Dating Relationships: The Contribution of Male Peer Support,” *Journal of Family Violence*, Vol. 10, No. 1, March 1995, pp. 41–53; , Stephen E. Humphrey and Arnold S. Kahn, “Fraternities, Athletic Teams, and Rape: Importance of Identification with a Risky Group,” *Journal of Interpersonal Violence*, Vol. 15, No. 12, December 2000, pp. 1313–1320.

⁵³ Theresa J. Brown, Kenneth E. Sumner, and Romy Nocera, “Understanding Sexual Aggression Against Women: An Examination of the Role of Men’s Athletic Participation and Related Variables,” *Journal of Interpersonal Violence*, Vol. 17, No. 9, September 2002, pp. 937–952; Elizabeth Ann Gage, “Gender Attitudes and Sexual Behaviors: Comparing Center and Marginal Athletes and Nonathletes in a Collegiate Setting,” *Violence Against Women*, Vol. 14, No. 9, September 2008, pp. 1014–1032; Gidycz, Warkentin, and Orchowski, 2007; Humphrey and Kahn, 2000; Mary P. Koss and John A. Gaines, “The Prediction of Sexual Aggression by Alcohol Use, Athletic Participation, and Fraternity Affiliation,” *Journal of Interpersonal Violence*, Vol. 8, No. 1, March 1993, pp. 94–108; Loh et al., 2005.

⁵⁴ Koss and Gaines, 1993.

⁵⁵ Humphrey and Kahn, 2000, p. 1314.

Stressful Life Events and Mental Health Problems

We did not find evidence of a strong, consistent empirical relationship between these factors and perpetrating a sexual assault.

Alcohol Intoxication

In nationally representative samples of civilians, about two-thirds of sexual assault victims indicate that the perpetrator was using alcohol at the time of the assault.⁵⁶ Evidence from controlled laboratory studies shows that alcohol use and intoxication are causally linked to increased general aggression in young men—particularly among men who are predisposed to behaving aggressively.⁵⁷ Although sexual violence cannot be studied directly in the laboratory for ethical reasons, indirect evidence suggests that alcohol use increases the risk of committing a sexual assault.⁵⁸ Young men who consume alcohol in a controlled laboratory setting are more likely to misperceive the sexual intent of women depicted in study materials,⁵⁹ take longer than men who have not consumed alcohol to identify that a sexual encounter in an audio track has turned into a date rape,⁶⁰ and are more likely to indicate that they would sexually assault someone in a situation similar to a hypothetical date-rape scenario.⁶¹ Although most of this research has been conducted with college men, this group does share demographic characteristics with junior enlisted personnel. Among victims of military sexual assaults, 37 percent indicate that the perpetrator had been drinking,⁶² suggesting that alcohol use might be one important risk factor for predicting sexual assault.⁶³

⁵⁶ Brecklin and Ullman, 2002; Tjaden and Thoennes, 2006.

⁵⁷ Brad J. Bushman and Harris M. Cooper, “Effects of Alcohol on Human Aggression: An Integrative Research Review,” *Psychological Bulletin*, Vol. 107, No. 3, May 1990, pp. 341–354; Stephen T. Chermack and Peter R. Giancola, “The Relation Between Alcohol and Aggression: An Integrated Biopsychosocial Conceptualization,” *Clinical Psychology Review*, Vol. 17, No. 6, September 1997, pp. 621–649; Tiffany A. Ito, Norman Miller, and Vicki E. Pollock, “Alcohol and Aggression: A Meta-Analysis on the Moderating Effects of Inhibitory Cues, Triggering Events, and Self-Focused Attention,” *Psychological Bulletin*, Vol. 120, No. 1, July 1996, pp. 60–82.

⁵⁸ Coreen Farris and Kimberly A. Hepner, *Targeting Alcohol Misuse: A Promising Strategy for Reducing Military Sexual Assaults?* Santa Monica, Calif.: RAND Corporation, RR-538-OSD, 2014.

⁵⁹ Coreen Farris, Teresa A. Treat, Richard J. Viken, and Richard M. McFall, “Sexual Coercion and the Misperception of Sexual Intent,” *Clinical Psychology Review*, Vol. 28, No. 1, January 2008, pp. 48–66.

⁶⁰ Alan M. Gross, Ted Bennett, Lawrence Sloan, Brian P. Marx, and John Juergens, “The Impact of Alcohol and Alcohol Expectancies on Male Perception of Female Sexual Arousal in a Date Rape Analog,” *Experimental and Clinical Psychopharmacology*, Vol. 9, No. 4, November 2001, pp. 380–388; Brian P. Marx, Alan M. Gross, and Henry E. Adams, “The Effect of Alcohol on the Responses of Sexually Coercive and Noncoercive Men to an Experimental Rape Analogue,” *Sexual Abuse: Journal of Research and Treatment*, Vol. 11, No. 2, April 1999, pp. 131–145.

⁶¹ Kelly C. Davis, “The Influence of Alcohol Expectancies and Intoxication on Men’s Aggressive Unprotected Sexual Intentions,” *Experimental and Clinical Psychopharmacology*, Vol. 18, No. 5, October 2010, pp. 418–428; Kelly Cue Davis, Trevor J. Schraufnagel, Angela J. Jacques-Tiura, Jeanette Norris, William H. George, and Preston A. Kiekel, “Childhood Sexual Abuse and Acute Alcohol Effects on Men’s Sexual Aggression Intentions,” *Psychological Violence*, Vol. 2, No. 2, April 1, 2012, pp. 179–193; Jeanette Norris, Kelly Cue Davis, William H. George, Joel Martell, and Julia R. Heiman, “Alcohol’s Direct and Indirect Effects on Men’s Self-Reported Sexual Aggression Likelihood,” *Journal of Studies on Alcohol*, Vol. 63, No. 6, November 2002, pp. 688–695.

⁶² NDRI, 2014.

⁶³ Farris and Hepner, 2014.

Access to the Means

For perpetration of sexual assault, *access to the means to engage* in the problematic behavior refers primarily to access to preferred victims in a private environment. Social norms for dating in the United States regularly create environments that can support sexual violence (i.e., private, isolated encounters with a selected partner). Although one might consider access to a weapon as relevant to the question, most sexual assaults do not involve a weapon;⁶⁴ the average-sized man can typically overpower an average-sized woman with his strength or body mass alone. Alcohol intoxication and incapacitation are also recognized as perpetration means that some offenders use because alcohol impairs a potential victim's ability to detect threats and resist an attacker.⁶⁵ A systematic review of factors associated with sexual violence found that men with more dating and sexual partners (the means to perpetrate) were, in fact, more likely to perpetrate sexual assault than men with fewer dating or sexual partners.⁶⁶ The positive association between number of partners and likelihood of sexual assault has been replicated in 18 studies; however, five studies showed null or mixed results.⁶⁷

Risk Factors Associated with Unlawful Discrimination

Although the U.S. military has a history of institutional discrimination, the current military is generally built on policies of EO⁶⁸ that, in many ways, represent ideal circumstances for overcoming racial prejudice.⁶⁹ However, the military is not monolithic, and some policies or situations within the military might evoke the unequal distribution of resources based on race and ethnicity.⁷⁰

Research on the factors associated with discrimination has a long history in the social sciences. More than 100 years of research on this topic have produced a strong empirical foundation using varying methods, including surveys of potential discriminators, studies of legal records, statistical analyses of employer practices, and scientific experiments.⁷¹

Engaged in Behavior Before

There are reasons to believe that people who have discriminated against the members of a group before are more likely than others to continue to discriminate against group members in the future. However, there is limited empirical evidence for this phenomenon. To the extent that the factors detailed next are consistent across time (e.g., people's negative attitudes about a group, an organizational context that does not discourage discrimination), it would be reason-

⁶⁴ Tjaden and Thoennes, 2006.

⁶⁵ Antonia Abbey, "Alcohol-Related Sexual Assault: A Common Problem Among College Students," *Journal of Studies on Alcohol*, Suppl. Vol. 14, March 2002, pp. 118–128.

⁶⁶ Tharp et al., 2013.

⁶⁷ Tharp et al., 2013.

⁶⁸ Sherie Mershon and Steven L. Schlossman, *Foxholes and Color Lines: Desegregating the U.S. Armed Forces*, Baltimore, Md.: Johns Hopkins University Press, 1998.

⁶⁹ Charles C. Moskos and John Sibley Butler, *All That We Can Be: Black Leadership and Racial Integration the Army Way*, New York: Basic Books, 1996.

⁷⁰ James Burk and Evelyn Espinoza, "Race Relations Within the US Military," *Annual Review of Sociology*, Vol. 38, No. 1, 2012, pp. 401–422.

⁷¹ Pager and Shepherd, 2008.

able to expect that people who have engaged in discriminatory practices in the past would be likely to discriminate again.

Attitudes About Behavior

The bulk of research on the factors associated with discrimination has centered on negative or prejudicial attitudes toward a group. Indeed, all things being equal, the link between prejudicial attitudes and discriminatory behavior is such a consistent finding that prejudicial attitudes are often the target of research.⁷² However, scholars make a theoretical distinction between discriminatory behavior and attitudes (prejudice), beliefs (stereotypes), and ideologies that support the status quo between groups.⁷³ Although numerous research studies have shown that people with more-prejudicial attitudes about a group are more likely than others to discriminate against members of that group, discrimination can occur without prejudice (see climate factors below), and prejudiced people do not always discriminate.⁷⁴

It is also important to distinguish between explicit prejudice (views that are consciously held and explicitly expressed) and implicit prejudice (automatic responses to a group that “commonly function without a person’s full awareness or control”).⁷⁵ Implicit prejudice can be present among people who endorse egalitarian views but who justify discrimination on other grounds (e.g., “they don’t share our values”).⁷⁶ Explicit prejudice is associated with more-overt forms of discrimination, such as negative comments⁷⁷ and judgments of guilt in mock trials.⁷⁸ Implicit prejudice is associated with more-spontaneous forms of discrimination, such as negative nonverbal behaviors during an interaction⁷⁹ and discriminatory selection of job candidates from résumés.⁸⁰

Climate

The aspects of organizational climate associated with prejudice and discrimination include the composition of the organization and group identity. Intergroup contact has been shown to *reduce* prejudice and discrimination under specific conditions: equal status between group members (e.g., group members are not segregated into leadership hierarchies), cooperative

⁷² John F. Dovidio, Peter Glick, and Laurie Rudman, eds., *On the Nature of Prejudice: Fifty Years After Allport*, Wiley-Blackwell, June 2005; Gordon W. Allport, *The Nature of Prejudice*, Cambridge, Mass.: Addison-Wesley Publishing, 1954.

⁷³ Pager and Shepherd, 2008.

⁷⁴ Pager and Shepherd, 2008.

⁷⁵ John F. Dovidio, Kerry Kawakami, and Samuel L. Gaertner, “Implicit and Explicit Prejudice and Interracial Interaction,” *Journal of Personality and Social Psychology*, Vol. 82, No. 1, January 2002, pp. 62–68, p. 62; Anthony G. Greenwald, T. Andrew Poehlman, Eric Luis Uhlmann, and Mahzarin R. Banaji, “Understanding and Using the Implicit Association Test: III. Meta-Analysis of Predictive Validity,” *Journal of Personality and Social Psychology*, Vol. 97, No. 1, July 2009, pp. 17–41.

⁷⁶ Samuel L. Gaertner and John F. Dovidio, “The Aversive Form of Racism,” in John F. Dovidio and Samuel L. Gaertner, eds., *Prejudice, Discrimination, and Racism*, San Diego, Calif.: Academic Press, 1986, pp. 61–89.

⁷⁷ Dovidio, Kawakami, and Gaertner, 2002.

⁷⁸ John F. Dovidio, Kerry Kawakami, Craig Johnson, Brenda Johnson, and Adaiah Howard, “On the Nature of Prejudice: Automatic and Controlled Processes,” *Journal of Experimental Social Psychology*, Vol. 33, No. 5, September 1997, pp. 510–540.

⁷⁹ Dovidio, Kawakami, and Gaertner, 2002; Dovidio et al., 1997.

⁸⁰ John F. Dovidio and Samuel L. Gaertner, “Aversive Racism and Selection Decisions: 1989 and 1999,” *Psychological Science*, Vol. 11, No. 4, July 2000, pp. 315–319.

interdependence (e.g., group members cooperate with each other to reach goals), opportunity for cross-group interactions, and sanction by group leaders.⁸¹ Although there have been some conflicting studies, groups that embody all the conditions that contact theory stipulates are associated with decreased prejudice and discrimination with respect to a wide range of groups, such as straight and gay or lesbian medical students,⁸² black and white Americans,⁸³ Muslims and non-Muslims,⁸⁴ and Catholics and Protestants in Northern Ireland.⁸⁵

In addition, organizations that foster a common organizational identity among members have less prejudice and discrimination among people from different groups.⁸⁶ Having a common group identity means that members of an organization put an emphasis on their shared organizational membership over their individual group (e.g., identifying more strongly with common military service membership rather than one's individual race or ethnicity).

Stressful Life Events, Mental Health Problems, and Alcohol Intoxication

We did not find evidence of a strong, consistent empirical relationship between these risk factors and discrimination.

Access to Means

The principal way in which access to means has been studied in discrimination research is through assessments of organizational policies designed to limit individual employees from engaging in discriminatory practices. Formalized organizational procedures that limit individual employees' ability to make discriminatory work-based decisions—such as hiring, salary increases, and promotions—are associated with reduced bias in organizational decisions.⁸⁷ For example, using concrete performance indicators and formalized evaluation systems reduces racial bias in performance evaluations⁸⁸ and unequal pay between men and women.⁸⁹ Formal-

⁸¹ Thomas F. Pettigrew and Linda R. Tropp, "A Meta-Analytic Test of Intergroup Contact Theory," *Journal of Personality and Social Psychology*, Vol. 90, No. 5, May 2006, pp. 751–783; Thomas F. Pettigrew, "Intergroup Contact Theory," *Annual Review of Psychology*, Vol. 49, 1998, pp. 65–85.

⁸² Sara E. Burke, John F. Dovidio, Julia M. Przedworski, Rachel R. Hardeman, Sylvia P. Perry, Sean M. Phelan, David B. Nelson, Diana J. Burgess, Mark W. Yeazel, and Michelle van Ryn, "Do Contact and Empathy Mitigate Bias Against Gay and Lesbian People Among Heterosexual First-Year Medical Students? A Report from the Medical Student CHANGE Study," *Academic Medicine*, Vol. 90, No. 5, May 2015, pp. 645–651.

⁸³ Thomas F. Pettigrew, Linda R. Tropp, Ulrich Wagner, and Oliver Christ, "Recent Advances in Intergroup Contact Theory," *International Journal of Intercultural Relations*, Vol. 35, No. 3, May 2011, pp. 271–280.

⁸⁴ Rhiannon N. Turner and Keon West, "Behavioural Consequences of Imagining Intergroup Contact with Stigmatized Outgroups," *Group Processes and Intergroup Relations*, Vol. 15, No. 2, March 2012, pp. 193–202.

⁸⁵ For a recent review, see Ben Fell and Miles Hewstone, "Contact and Prejudice," in Steven Vertovec, ed., *Routledge International Handbook of Diversity Studies*, Part IV: *Encounters and Diversity*, New York: Routledge, 2015, pp. 284–293.

⁸⁶ John F. Dovidio, Samuel L. Gaertner, and Ana Validzic, "Intergroup Bias: Status, Differentiation, and a Common In-Group Identity," *Journal of Personality and Social Psychology*, Vol. 75, No. 1, July 1998, pp. 109–120; Samuel L. Gaertner and John F. Dovidio, *Reducing Intergroup Bias: The Common Ingroup Identity Model*, Philadelphia, Pa.: Psychology Press, 2000.

⁸⁷ Pager and Shepherd, 2008.

⁸⁸ Linda Hamilton Krieger, "The Content of Our Categories: A Cognitive Bias Approach to Discrimination and Equal Employment Opportunity," *Stanford Law Review*, Vol. 47, No. 6, July 1995, pp. 1161–1248; Barbara F. Reskin, "The Proximate Causes of Employment Discrimination," *Contemporary Sociology*, Vol. 29, No. 2, March 2000, pp. 319–328.

⁸⁹ Marta M. Elvira and Mary E. Graham, "Not Just a Formality: Pay System Formalization and Sex-Related Earnings Effects," *Organization Science*, Vol. 13, No. 6, November–December 2002, pp. 601–617.

ized systems are also associated with increased promotion rates for women.⁹⁰ The military is often cited as an example of an organization “in which highly rationalized systems of hiring, promotion, and remuneration are associated with an increasing representation of minorities, greater racial diversity in positions of authority, and a smaller racial wage gap.”⁹¹

Risk Factors Associated with Substance Abuse

Extensive research has been conducted on the risk factors for adolescent substance abuse.⁹² However, given that the influence of various risk factors can vary with age (e.g., family risk factors might be greater for younger children and drug-using peers greater for adolescents),⁹³ studies conducted with emerging adults (that is, people between the ages of 18 and 26) might be most relevant to military populations. As such, we relate findings from a recent comprehensive review that focused on longitudinal predictors of substance use and abuse in the emerging-adulthood population to the shared risk-factor categories identified for this study’s problematic behaviors.⁹⁴ When relevant, we draw on findings from other reviews conducted with military or college-student populations.

Engaged in Behavior Before

The risk for substance use and misuse in young adulthood is greater for people who have used the same substance in adolescence than for abstainers.⁹⁵ Multiple studies have established this link for alcohol⁹⁶ and illicit drugs, including marijuana.⁹⁷ Moreover, the earlier the age of onset

⁹⁰ Kevin Stainback, Donald Tomaskovic-Devey, and Sheryl Skaggs, “Organizational Approaches to Inequality: Inertia, Relative Power, and Environments,” *Annual Review of Sociology*, Vol. 36, No. 1, August 2010, pp. 225–247.

⁹¹ Pager and Shepherd, 2008, p. 14.

⁹² For example, Jennifer M. Beyers, John W. Toumbourou, Richard F. Catalano, Michael W. Arthur, and J. David Hawkins, “A Cross-National Comparison of Risk and Protective Factors for Adolescent Substance Use: The United States and Australia,” *Journal of Adolescent Health*, Vol. 35, No. 1, July 2004, pp. 3–16; J. David Hawkins, Richard F. Catalano, and Janet Y. Miller, “Risk and Protective Factors for Alcohol and Other Drug Problems in Adolescence and Early Adulthood: Implications for Substance Abuse Prevention,” *Psychological Bulletin*, Vol. 112, No. 1, 1992, pp. 64–105; Krzysztof Ostaszewski and Marc A. Zimmerman, “The Effects of Cumulative Risks and Promotive Factors on Urban Adolescent Alcohol and Other Drug Use: A Longitudinal Study of Resiliency,” *American Journal of Community Psychology*, Vol. 38, No. 3, December 2006, pp. 237–249.

⁹³ Elizabeth B. Robertson, Susan L. David, and Suman A. Rao, *Preventing Drug Abuse Among Children and Adolescents: A Research-Based Guide for Parents, Educators, and Community Leaders*, 2nd ed., Bethesda, Md.: U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, October 2003.

⁹⁴ Andrea L. Stone, Linda G. Becker, Alice M. Huber, and Richard F. Catalano, “Review of Risk and Protective Factors of Substance Use and Problem Use in Emerging Adulthood,” *Addictive Behaviors*, Vol. 37, No. 7, July 2012, pp. 747–775.

⁹⁵ Stone et al., 2012.

⁹⁶ For example, Kate Flory, Donald Lynam, Richard Milich, Carl Leukefeld, and Richard Clayton, “Early Adolescent Through Young Adult Alcohol and Marijuana Use Trajectories: Early Predictors, Young Adult Outcomes, and Predictive Utility,” *Development and Psychopathology*, Vol. 16, No. 1, March 2004, pp. 193–213; Jie Guo, Linda M. Collins, Karl G. Hill, and J. David Hawkins, “Developmental Pathways to Alcohol Abuse and Dependence in Young Adulthood,” *Journal of Studies on Alcohol*, Vol. 61, No. 6, 2000, pp. 799–808; Kathleen M. Roche, Saiffudin Ahmed, and Robert W. Blum, “Enduring Consequences of Parenting for Risk Behaviors from Adolescence into Early Adulthood,” *Social Science and Medicine*, Vol. 66, No. 9, May 2008, pp. 2023–2034.

⁹⁷ For example, Flory et al., 2004; Wendy Swift, Carolyn Coffey, John B. Carlin, Louisa Degenhardt, and George C. Patton, “Adolescent Cannabis Users at 24 Years: Trajectories to Regular Weekly Use and Dependence in Young Adulthood,” *Addiction*, Vol. 103, No. 8, August 2008, pp. 1361–1370; Michael Windle and Margit Wiesner, “Trajectories of Marijuana

of use, the greater the risk for subsequent SUDs.⁹⁸ Some studies have also shown that the use of one substance in adolescence can increase risk for the use and misuse of other substances in early adulthood. Adolescent heavy alcohol use has been connected to heavy drug use in young adulthood,⁹⁹ adolescents who use marijuana are more likely engage in subsequent use of other illicit drugs,¹⁰⁰ and tobacco use in adolescence has been linked to an increased risk of alcohol and substance abuse in early adulthood.¹⁰¹

Attitudes Toward Behavior

Stone and colleagues' review¹⁰² of longitudinal predictors of substance use and misuse in emerging adults identified three studies that established a link between alcohol attitudes and expectancies and subsequent alcohol misuse. In one study of urban school students, positive attitudes toward alcohol use at ages 10 and 16 predicted alcohol abuse at age 21.¹⁰³ In a national study, positive attitudes toward alcohol use were significantly associated with an increased risk for heavy alcohol use from ages 18 to 26.¹⁰⁴ The third study, which was conducted with young adults who had family history of alcoholism, determined that the risk for alcohol abuse was fully mediated by alcohol expectancy and personality measures.¹⁰⁵ No studies on illicit-drug use were identified. Cross-sectional studies conducted with college populations have demonstrated significant associations between positive drug expectancies and marijuana use.¹⁰⁶

Climate

There are conflicting findings about the influence that perceived drinking norms can have on risk for alcohol use in young adults.¹⁰⁷ In cross-sectional studies, misperceptions about student drinking on campus (e.g., believing that a greater proportion of students use alcohol than actual estimates) have been associated with increases in harmful drinking behaviors, and

Use from Adolescence to Young Adulthood: Predictors and Outcomes," *Development and Psychopathology*, No. 4, December 2004, pp. 1007–1027.

⁹⁸ Stone et al., 2012.

⁹⁹ J. S. Brook, E. B. Balka, Y. Ning, and D. W. Brook, "Trajectories of Cigarette Smoking Among African Americans and Puerto Ricans from Adolescence to Young Adulthood: Associations with Dependence on Alcohol and Illegal Drugs," *American Journal on Addictions*, Vol. 16, No. 3, May–June 2007, pp. 195–201.

¹⁰⁰ Jeffrey M. Lessem, Christian J. Hopfer, Brett C. Haberstick, David Timberlake, Marissa A. Ehringer, Andrew Smolen, and John K. Hewitt, "Relationship Between Adolescent Marijuana Use and Young Adult Illicit Drug Use," *Behavior Genetics*, Vol. 36, No. 4, July 2006, pp. 498–506.

¹⁰¹ Brook et al., 2007.

¹⁰² Stone et al., 2012.

¹⁰³ Guo et al., 2000.

¹⁰⁴ Kristina M. Jackson and Kenneth J. Sher, "Conjoint Developmental Trajectories of Young Adult Alcohol and Tobacco Use," *Journal of Abnormal Psychology*, Vol. 114, No. 4, November 2005, pp. 612–626.

¹⁰⁵ Kristina M. Jackson, Kenneth J. Sher, and Phillip K. Wood, "Trajectories of Concurrent Substance Use Disorders: A Developmental, Typological Approach to Comorbidity," *Alcoholism: Clinical and Experimental Research*, Vol. 24, No. 6, June 2000, pp. 902–913.

¹⁰⁶ Raluca M. Gaher and Jeffrey S. Simons, "Evaluations and Expectancies of Alcohol and Marijuana Problems Among College Students," *Psychology of Addictive Behaviors*, Vol. 21, No. 4, December 2007, pp. 545–554; Jason R. Kilmer, Scott B. Hunt, Christine M. Lee, and Clayton Neighbors, "Marijuana Use, Risk Perception, and Consequences: Is Perceived Risk Congruent with Reality?" *Addictive Behaviors*, Vol. 32, No. 12, December 2007, pp. 3026–3033.

¹⁰⁷ Stone et al., 2012.

peer drinking norms have been linked to alcohol use and misuse.¹⁰⁸ However, no significant associations were found between peer drinking norms and alcohol use when age at first use was accounted for.¹⁰⁹ Further, a national evaluation of social norms marketing interventions to reduce heavy alcohol use among college students did not yield consistent positive findings.¹¹⁰

Stressful Life Events

The impact of stressful life events has mainly been established as a risk factor for young-adult alcohol and substance use or misuse, but not for abuse.¹¹¹ In a community study that examined drinking trajectories from adolescence to young adulthood (ages 16 to 25), compared with their respective “non–heavy drinking stable” groups, men were 3.7 times and women 1.8 times more likely to be members of the “high heavy drinking stable” group when they reported more stressful life events.¹¹² In a study of children of alcoholics, stressful life events in adolescence and young adulthood were related to a greater likelihood of young-adult drug use.¹¹³ Similarly, in a study conducted with a community sample in Switzerland, young adults who engaged in heavy or problem alcohol use reported significantly more and worse stressful life events.¹¹⁴ For military populations, factors associated with increased alcohol use or misuse include deployment to any operational theater, higher frequency of deployment, greater cumulative time deployed, perceived high work stress, and exposure to the threat of death or injury.¹¹⁵ In addition, legal problems and poor family support have been associated with an increased risk of opioid misuse among Army service members.¹¹⁶

Mental Health Problems

The large majority of studies examining whether psychiatric problems predict subsequent substance use or misuse in young adults focus on internalizing and externalizing behaviors rather than behaviors that reach the clinical threshold of a mental health problem.¹¹⁷ Internalizing problematic behavior can encompass negative affect, depressive symptoms or disorders, anxiety, or low levels of well-being.¹¹⁸ Externalizing behaviors has been operationalized as delinquency,

¹⁰⁸Stone et al., 2012.

¹⁰⁹Erica Weintraub Austin and Yin Ju Chen, “The Relationship of Parental Reinforcement of Media Messages to College Students’ Alcohol-Related Behaviors,” *Journal of Health Communication*, Vol. 8, No. 2, 2003, pp. 157–169.

¹¹⁰H. Wechsler, T. E. Nelson, J. E. Lee, M. Seibring, C. Lewis, and R. P. Keeling, “Perception and Reality: A National Evaluation of Social Norms Marketing Interventions to Reduce College Students’ Heavy Alcohol Use,” *Journal of Studies on Alcohol*, Vol. 64, No. 4, July 2003, pp. 484–494.

¹¹¹Stone et al., 2012.

¹¹²Michael Windle, Eun Young Mun, and Rebecca C. Windle, “Adolescent-to–Young Adulthood Heavy Drinking Trajectories and Their Prospective Predictors,” *Journal of Studies on Alcohol*, Vol. 66, No. 3, 2005, pp. 313–322.

¹¹³Andrea M. Hussong and Laurie Chassin, “Stress and Coping Among Children of Alcoholic Parents Through the Young Adult Transition,” *Developmental Psychopathology*, Vol. 16, No. 4, Fall 2004, pp. 985–1006.

¹¹⁴Hans-Christoph Steinhausen and Christa Winkler Metzke, “The Validity of Adolescent Types of Alcohol Use,” *Journal of Child Psychology and Psychiatry*, Vol. 44, No. 5, July 2003, pp. 677–686.

¹¹⁵IOM, 2013.

¹¹⁶Department of the Army, *Sexual Harassment/Assault Response and Prevention (SHARP) Program Implementation Guidance*, All Army Activity 007/2012, January 2012, as cited in IOM, 2013.

¹¹⁷Stone et al., 2012.

¹¹⁸Stone et al., 2012.

deviance, antisocial or conduct problems, aggression, and hyperactivity.¹¹⁹ Two studies that examined whether mental health problems predicted future substance use or misuse presented conflicting findings.¹²⁰ One study found no significant association between MDD at age 17 and drug and alcohol abuse in young adulthood.¹²¹ In contrast, co-occurring anxiety and alcohol use disorders at age 19 were associated with greater risk for heavy alcohol use at age 25 than among counterparts at 19 who had no disorder, a single disorder, or co-occurring depression and drug abuse.¹²² Among active-duty service members, cross-sectional associations have been found between a PTSD diagnosis and increased alcohol use or misuse.¹²³ Among Army service members, having a major psychiatric disorder has been associated with an increased risk for opioid use. Among National Guard members, depression and PTSD symptoms have been identified as risk factors for alcohol misuse, and PTSD symptom severity was found to predict alcohol use disorder.¹²⁴

Alcohol Intoxication

We did not find evidence of a strong, consistent empirical relationship between this risk factor and SUDs. This does not mean that alcohol intoxication is not a risk factor; rather, the fact that we did not find the evidence could be because longitudinal studies focused on other risk factors besides alcohol intoxication, such as age of onset of use, frequency of drinking, and heavy drinking.

Access to Means

Cross-sectional associations have been established between the number of liquor retailers in surrounding areas of college campuses and increased risk for heavy alcohol use and intoxication. However, no longitudinal studies examining whether changes in the availability of liquor retailers predict subsequent risk for alcohol misuse or abuse could be identified at the time of Stone et al.'s review.¹²⁵ A range of cross-sectional studies have demonstrated significant relationships between risk for alcohol use or misuse and policies related to minimum legal drinking ages, driving policies, and sales of alcohol.¹²⁶ For example, reductions in binge drinking have been associated with stricter state-level policies on lawful blood alcohol concentration levels for driving, happy hours, open containers, beer sold in pitchers, and advertising in national

¹¹⁹ Stone et al., 2012.

¹²⁰ Stone et al., 2012.

¹²¹ Naomi R. Marmorstein, William G. Iacono, and Stephen M. Malone, "Longitudinal Associations Between Depression and Substance Dependence from Adolescence Through Early Adulthood," *Drug and Alcohol Dependence*, Vol. 107, No. 2–3, March 1, 2010, pp. 154–160.

¹²² Ron Vida, E. B. Brownlie, Joseph H. Beitchman, Edward M. Adlaf, Leslie Atkinson, Michael Escobar, Carla J. Johnson, Hedy Jiang, Emiko Koyama, and Danielle Bender, "Emerging Adult Outcomes of Adolescent Psychiatric and Substance Use Disorders," *Addictive Behaviors*, Vol. 34, No. 10, October 2009, pp. 800–805.

¹²³ IOM, 2013.

¹²⁴ IOM, 2013.

¹²⁵ Stone et al., 2012.

¹²⁶ Stone et al., 2012.

young-adult and college study samples.¹²⁷ However, a cross-sectional study of college students found differential effects across gender, with drinking and driving policies being significantly associated with decreases in binge drinking for men but not women.¹²⁸ In a meta-analysis of more than 100 studies, higher alcohol taxation and pricing were significantly associated with decreased alcohol use and heavy drinking.¹²⁹

Risk Factors Associated with Suicide

Comprehensive reviews have highlighted the multitudinous and complex nature of risk factors associated with suicide.¹³⁰ This section provides a brief overview of findings drawn from these reviews that are relevant to our identified risk factors.

Engaged in Behavior Before

The strongest predictor for subsequent suicide risk is a prior suicide attempt.¹³¹ Someone with a prior suicide attempt is approximately 40 times more likely to subsequently die from suicide relative to individuals without previous attempts.¹³² Moreover, prior suicide attempts have been found to be predictive of future suicidal risk even when accounting for other risk factors that have been associated with suicide.¹³³

Attitudes About Behavior

We did not find evidence of a strong, consistent empirical relationship between attitudes about suicide and suicide.

Climate

Evidence for the role of climate and social norms comes from studies that have documented increases in suicide upon exposure to suicide either temporally, geographically, via media, or through one's peers.¹³⁴ Ramchand et al., 2011, notes that, although there is not a strong evidence base supporting the clustering of suicides among adults, there have been cases suggesting

¹²⁷Toben F. Nelson, Timothy S. Naimi, Robert D. Brewer, and Henry Wechsler, "The State Sets the Rate: The Relationship Among State-Specific College Binge Drinking, State Binge Drinking Rates, and Selected State Alcohol Control Policies," *American Journal of Public Health*, Vol. 95, No. 3, March 2005, pp. 441–446.

¹²⁸Frank J. Chaloupka and Henry Wechsler, "Binge Drinking in College: The Impact of Price, Availability, and Alcohol Control Policies," *Contemporary Economic Policy*, Vol. 14, No. 4, October 1996, pp. 112–124.

¹²⁹A. C. Wagenaar, M. J. Salois, and K. A. Komro, "Effects of Beverage Alcohol Price and Tax Levels on Drinking: A Meta-Analysis of 1003 Estimates from 112 Studies," *Addiction*, Vol. 104, No. 2, February 2009, pp. 179–190.

¹³⁰S. K. Goldsmith, T. C. Pellmar, A. M. Kleinman, and W. E. Bunney, eds., *Reducing Suicide: A National Imperative*, Washington, D.C.: National Academies Press, 2002; Denning, Meisner, and Warner, 2014; Matthew K. Nock, Charlene A. Deming, Carol S. Fullerton, Stephen E. Gilman, Matthew Goldenberg, Ronald C. Kessler, James E. McCarroll, Katie A. McLaughlin, Christopher Peterson, Michael Schoenbaum, Barbara Stanley, and Robert J. Ursano, "Suicide Among Soldiers: A Review of Psychosocial Risk and Protective Factors," *Psychiatry*, Vol. 76, 2013, pp. 97–125; Ramchand et al., 2011; U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012; World Health Organization (WHO), *Preventing Suicide: A Global Imperative*, Geneva, 2014.

¹³¹Nock, Deming, et al., 2013; Ramchand et al., 2011; WHO, 2014.

¹³²E. Clare Harris and Brian Barraclough, "Suicide as an Outcome for Mental Disorders: A Meta-Analysis," *British Journal of Psychiatry*, Vol. 170, No. 3, 1997, pp. 205–228.

¹³³Nock, Deming, et al., 2013.

¹³⁴Ramchand et al., 2011; WHO, 2014.

possible instances of clustering in the U.S. Navy,¹³⁵ Army,¹³⁶ and National Guard.¹³⁷ In addition, exposure to media that either sensationalize suicide or normalize it as an acceptable way to cope with difficulties have been linked to increased risk for suicide among those who might be vulnerable to such behaviors.¹³⁸ In their synopsis of the literature, Ramchand and his colleagues point out that the evidence for increased risk of suicide associated with media coverage of suicides through television or the Internet is less conclusive than the increased risk associated with newspaper coverage.¹³⁹ Still, a recent WHO report cites the Internet as one of the leading sources of information about suicide and raises concerns about the accessibility of inappropriate portrayals of suicide via this medium.¹⁴⁰ Finally, suicide risk has been associated with exposure to suicide attempts or deaths among one's peers. However, it is unclear how much this is related to a tendency for people who are inclined toward engaging in suicidal behaviors to associate with one another or whether being exposed to someone who engages in suicidal behaviors affects one's own propensity toward such behaviors.¹⁴¹

Stressful Life Events

Life stresses have been associated with an increased risk for suicide.¹⁴² People who have attempted or died by suicide have been found to have more life stresses.¹⁴³ Ramchand and his colleagues note that, although specific life stresses and the cumulative number of life stresses have been associated with increased risk for suicide, recent research suggests that this risk might be more related to how people respond to negative life events, which might be influenced by such factors as prior mental health problems or suicide attempts that make one more susceptible to suicide.¹⁴⁴ Among U.S. Army service members who died by suicide, intimate-partner problems (41 percent) and military-related stress (41 percent) were the most-prevalent life stresses present prior to the suicide.¹⁴⁵ The most-common military-related stresses included combat experiences in recent deployments and job-related problems. In a cross-sectional study of active-duty service members during 2005 and 2007, stresses, such as separation or divorce and reduction in rank, were associated with increased incidence of suicide.¹⁴⁶ In 2013, across all services, the most-prevalent life stresses that preceded suicides were failed relationships (45 per-

¹³⁵Laurel L. Hourani, Giles Warrack, and Patricia A. Cohen, "A Demographic Analysis of Suicide Among U.S. Navy Personnel," *Suicide and Life-Threatening Behavior*, Vol. 29, No. 4, Winter 1999, pp. 365–375.

¹³⁶"Army Will Investigate Recruiters' Suicides," *New York Times*, November 8, 2008.

¹³⁷Erica Goode, "Suicide's Rising Toll: After Combat, Victims of an Inner War," *New York Times*, August 1, 2009.

¹³⁸WHO, 2014.

¹³⁹Ramchand et al., 2011.

¹⁴⁰WHO, 2014.

¹⁴¹Ramchand et al., 2011.

¹⁴²Goldsmith et al., 2002.

¹⁴³Ramchand et al., 2011.

¹⁴⁴Ramchand et al., 2011.

¹⁴⁵J. Logan, N. A. Skopp, D. Karch, M. A. Reger, and G. A. Gahm, "Characteristics of Suicides Among US Army Active Duty Personnel in 17 US States from 2005 to 2007," *American Journal of Public Health*, Vol. 102, Supp. 1, March 2012, pp. S40–S44.

¹⁴⁶Jeffrey Hyman, Robert Ireland, Lucinda Frost, and Linda Cottrell, "Suicide Incidence and Risk Factors in an Active Duty US Military Population," *American Journal of Public Health*, Vol. 102, No. S1, March 2012, pp. S138–S146.

cent), followed by administrative legal issues (30 percent) and financial and workplace difficulties (24 percent).¹⁴⁷ Although deployment has been seen as increasing the risk of experiencing stressors,¹⁴⁸ a recent study found no significant association between deployment and risk for suicide among U.S. military personnel who had served in Operation Enduring Freedom or Operation Iraqi Freedom.¹⁴⁹ Interestingly, separation from service (regardless of having been deployed or not), especially among those with separations occurring with less than four years of military service or without an honorable discharge, was associated with increased suicide risk.

Mental Health Problems

Evidence of a mental health problem has been found in deaths by suicide, compared with controls in case-control studies.¹⁵⁰ Ramchand and colleagues highlight depression and anxiety disorders (including PTSD) as mental health problems that might be particularly relevant in identifying risk for suicide among military personnel, given that other disorders, such as schizophrenia or borderline personality disorder, which carry increased risk for suicide, are typically grounds for excluding enrollment into the military.¹⁵¹ Citing estimates reported by the Congressional Research Service, a 2014 IOM report on preventing psychological disorders in service members notes that a significant proportion of mental health diagnoses between 2000 and 2011 were made up of depression (17 percent), anxiety excluding PTSD (10 percent), and PTSD (6 percent).¹⁵² Depression is one the most-prevalent mental health problems associated with suicide,¹⁵³ but only a small proportion of people with depression (approximately 4 percent) will die by suicide.¹⁵⁴

The recent large-scale Army Study to Assess Risk and Resilience in Servicemembers examined the association between eight internalizing disorders (MDD, bipolar disorder, panic disorder, generalized anxiety disorder, PTSD, specific phobia, social phobia, and obsessive-compulsive disorder) and three externalizing disorders (attention-deficit/hyperactivity disorder, intermittent explosive disorder [IED], and SUDs).¹⁵⁵ When the effects of all the mental health problems are accounted for, only preenlistment panic disorder, PTSD, and IED and postenlistment MDD and IED exhibit significant associations with first suicide attempts occurring

¹⁴⁷ Mark A. Reger, Derek J. Smolenski, Nancy A. Skopp, Melinda J. Metzger-Abamukang, Han K. Kang, Tim A. Bullman, Sondra Perdue, and Gregory A. Gahm, "Risk of Suicide Among US Military Service Members Following Operation Enduring Freedom or Operation Iraqi Freedom Deployment and Separation from the Military," *JAMA Psychiatry*, Vol. 72, No. 6, June 2015, pp. 561–569.

¹⁴⁸ Ramchand et al., 2011.

¹⁴⁹ Reger et al., 2015.

¹⁵⁰ J. T. Cavanagh, A. J. Carson, M. Sharpe, and S. M. Lawrie, "Psychological Autopsy Studies of Suicide: A Systematic Review," *Psychological Medicine*, Vol. 33, No. 3, April 2003, pp. 395–405.

¹⁵¹ Ramchand et al., 2011.

¹⁵² Denning, Meisnere, and Warner, 2014.

¹⁵³ Cavanagh et al., 2003.

¹⁵⁴ Goldsmith et al., 2002.

¹⁵⁵ Matthew K. Nock, Murray B. Stein, Steven G. Heeringa, Robert J. Ursano, Lisa J. Colpe, Carol S. Fullerton, Irving Hwang, James A. Naifeh, Nancy A. Sampson, Michael Schoenbaum, Alan M. Zaslavsky, and Ronald C. Kessler, "Prevalence and Correlates of Suicidal Behavior Among Soldiers: Results from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS)," *JAMA Psychiatry*, Vol. 71, No. 5, May 2014, pp. 514–522.

postenlistment. Interestingly, inverse relationships were found for preenlistment panic disorder and PTSD, which were associated with lower odds of postenlistment first suicide attempts (conflicting with findings from previous civilian studies).¹⁵⁶ This could be because of the receipt of mental health treatment prior to enlistment. Alternatively, preenlistment PTSD and panic disorders might be an indicator of resilience among people who enlist in the Army.¹⁵⁷ For suicides across all services in 2013, 40 percent of the cases involved history of a behavioral health diagnosis—most commonly, mood disorders.¹⁵⁸

Numerous reviews have identified SUD as a significant risk factor for suicide.¹⁵⁹ Approximately one-quarter to one-half of all people who die by suicide have evidence of alcohol and other SUDs.¹⁶⁰ SUDs have been associated with approximately six times greater risk for serious suicide attempts for men and four times greater risk for women.¹⁶¹ For suicides across all services in 2013, 21 percent of the cases involved history of substance abuse.¹⁶² Moreover, 53 percent of suicides involved alcohol use, and 30 percent involved drug use.

Although the presence of mental and substance use disorders have been documented in a substantial proportion of cases of suicide, most people with these challenges do not die by suicide. Investigations that have attempted to identify factors that distinguish those who have engaged in suicidal behaviors and those who have not among people with mental or substance use disorders have indicated that hopelessness, impulsivity, aggressiveness, and poor problem-solving appear to play important roles.¹⁶³

Access to Means

Accessibility to common means of suicide, such as firearms, has been associated with increased risk for suicide.¹⁶⁴ Strong associations between firearms in the home and deaths by suicide have been demonstrated across all age groups, but the relationship is particularly robust for those under 25 years old.¹⁶⁵ The likelihood of using a gun as the method for suicide increased 31 to 108 more times if a firearm was in the home.¹⁶⁶ Other aspects of increased accessibility,

¹⁵⁶Nock, Stein, et al., 2014.

¹⁵⁷Nock, Stein, et al., 2014.

¹⁵⁸Reger et al., 2015.

¹⁵⁹U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012; Goldsmith et al., 2002; Ramchand et al., 2011; WHO, 2014.

¹⁶⁰Barbara Schneider, "Substance Use Disorders and Risk for Completed Suicide," *Archives of Suicide Research*, Vol. 13, 2009, pp. 303–316.

¹⁶¹B. E. Molnar, L. F. Berkman, and S. L. Buka, "Psychopathology, Childhood Sexual Abuse and Other Childhood Adversities: Relative Links to Subsequent Suicidal Behavior in the US," *Psychological Medicine*, Vol. 31, No. 6, August 2001, pp. 965–977.

¹⁶²Reger et al., 2015.

¹⁶³Ramchand et al., 2011.

¹⁶⁴Goldsmith et al., 2002.

¹⁶⁵Goldsmith et al., 2002.

¹⁶⁶David A. Brent, Joshua A. Perper, Christopher J. Allman, Grace M. Moritz, Mary E. Wartella, and Janice P. Zelenak, "The Presence and Accessibility of Firearms in the Homes of Adolescent Suicides: A Case-Control Study," *Journal of the American Medical Association*, Vol. 266, No. 21, December 4, 1991, pp. 2989–2995; Annette L. Beautrais, Peter R. Joyce, and Roger T. Mulder, "Access to Firearms and the Risk of Suicide: A Case Control Study," *Australian and New Zealand Journal of Psychiatry*, Vol. 30, No. 6, 1996, pp. 741–748.

such as the availability of loaded guns or unlocked stored guns, are related to greater odds of suicide risk.¹⁶⁷ Correspondingly, stricter gun-control laws have also been linked to reductions in overall and gun-related suicide rates. The availability of firearms is particularly relevant for service members who have access to firearms in their workplaces and who are more likely to possess a personal gun than the general U.S. population.¹⁶⁸ For suicides across all services in 2013, 61 percent involved the use of a firearm (mostly non–military issued), and 29 percent involved hanging or asphyxiation.¹⁶⁹ Policy changes, such as requiring analgesics to be packaged in blister packs and instituting purchasing limits, are one strategy to reduce access to the means for overdose suicides and have been shown in the United Kingdom to effectively reduce the number of suicides.¹⁷⁰

Risk Factors Associated with Hazing

Research on hazing risk factors is extremely limited. In fact, no existing evidence met the threshold of our review in terms of the rigor necessary to support a consistent association between the risk factors in our model and hazing. However, in the interest of including hazing as part of our review, we have included a review of potential risk factors for hazing, all of which are based on limited qualitative and survey research. This explains why there are no *xs* in in the hazing column of Table 2.1.

Engaged in Behavior Before

We did not identify studies examining the relationship between this risk factor and hazing.

Attitudes About the Behavior

In groups in which hazing is accepted as a behavior supported to join that group, it follows that hazing would be more likely to occur. Some researchers have suggested that participating in ritual-like behavior, such as hazing, signals commitment and loyalty to the group.¹⁷¹ Keller and colleagues build from the theory of cognitive dissonance to suggest that people might alter their attitudes about hazing in order to justify their participation in hazing behavior.¹⁷²

Climate

In line with supportive attitudes toward hazing, supportive group climate toward hazing suggests that this behavior is more likely to occur. Keller and colleagues note, “Proponents of hazing argue that acts of hazing or harsh initiation rituals contribute to increased liking of,

¹⁶⁷ Goldsmith et al., 2002.

¹⁶⁸ Goldsmith et al., 2002.

¹⁶⁹ Reger et al., 2015.

¹⁷⁰ Julia Buus Florentine and Catherine Crane, “Suicide Prevention by Limiting Access to Methods: A Review of Theory and Practice,” *Social Science and Medicine*, Vol. 70, No. 10, May 2010, pp. 1626–1632.

¹⁷¹ Joseph Henrich, “The Evolution of Costly Displays, Cooperation and Religion: Credibility Enhancing Displays and Their Implications for Cultural Evolution,” *Evolution and Human Behavior*, Vol. 30, No. 4, July 2009, pp. 244–260; Richard Sosis, Howard C. Kress, and James S. Boster, “Scars for War: Evaluating Alternative Signaling Explanations for Cross-Cultural Variance in Ritual Costs,” *Evolution and Human Behavior*, Vol. 28, No. 4, July 2007, pp. 234–247.

¹⁷² Kirsten M. Keller, Miriam Matthews, Kimberly Curry Hall, William Marcellino, Jacqueline A. Mauro, and Nelson Lim, *Hazing in the U.S. Armed Forces: Recommendations for Hazing Prevention Policy and Practice*, Santa Monica, Calif.: RAND Corporation, RR-941-OSD, 2015.

commitment to, and cohesion with the group.”¹⁷³ This supportive climate could perpetuate hazing behavior over time.

Stressful Life Events and Mental Health Problems

We did not find studies that examined the relationship between these risk factors and hazing.

Alcohol Intoxication

Alcohol is commonly involved in hazing activities.¹⁷⁴ Because of the impaired judgment and reduced inhibitions that result from alcohol intoxication, one could theorize that alcohol intoxication could increase the risk of sanctioned rituals getting out of hand and becoming hazing incidents.

Access to Means

Hazing occurs when existing members of a group subject potential new members of the group to abusive behaviors to achieve group membership. Thus, having a group structure that supports this framework of existing and new members provides the opportunity to engage in hazing behavior. Researchers have suggested that groups with hierarchical structures that have members who are in positions of power in a group, rather than groups that are more egalitarian in nature, present the opportunity and increase the likelihood of hazing to occur with new or subordinate members.¹⁷⁵ Additionally, veteran group members or members in positions of power can use hazing as a means to assert their dominance over newer members and maintain their positions in the group.¹⁷⁶ Keller and colleagues note that this can result in veteran members or members in positions of power using hazing to communicate the structure of a group and its hierarchy to new members.¹⁷⁷

Summary

Our review did not reveal research studies designed to identify common risk factors for sexual harassment, sexual assault, discrimination, substance abuse, suicide, and hazing. This is perhaps not surprising, given the breadth of these behaviors and their differing orientations. Sexual harassment, sexual assault, discrimination, and hazing are all externalized behaviors (i.e., behaviors that are directed toward other people), and some of these behaviors did appear to share risk factors (e.g., attitudes and climates that condone the behavior). Substance abuse and suicide are internalized behaviors (i.e., behaviors that are directed toward the self), and they shared in common associations with stressful life events and mental health problems.

¹⁷³ Keller et al., 2015, p. 26.

¹⁷⁴ Elizabeth J. Allan and Mary Madden, *Hazing in View: College Students at Risk—Initial Findings from the National Study of Student Hazing*, StopHazing, March 11, 2008.

¹⁷⁵ Caroline F. Keating, Jason Pomerantz, Stacy D. Pommer, Samantha J. H. Ritt, Lauren M. Miller, and Julie McCormick, “Going to College and Unpacking Hazing: A Functional Approach to Decrypting Initiation Practices Among Undergraduates,” *Group Dynamics: Theory, Research, and Practice*, Vol. 9, No. 2, June 2005, pp. 104–126.

¹⁷⁶ Aldo Cimino, “The Evolution of Hazing: Motivational Mechanisms and the Abuse of Newcomers,” *Journal of Cognition and Culture*, Vol. 11, 2011, pp. 241–267.

¹⁷⁷ Keller et al., 2015.

Three risk-factor categories emerged as the most common across behaviors: attitudes about the behavior, access to means, and climate. These factors fit into the three stages of our conceptual model—propensity to engage (e.g., supportive attitudes), problematic behavior disinhibited (e.g., organizational climate), and access to means—and are suggestive of potential shared risk factors across behaviors. Interestingly, research on attitudes has shown that attitudes are most predictive of behaviors when they are specific to the behavior and when the situation supports the attitude–behavior connection.¹⁷⁸ Thus, attitudes might be best able to predict problematic behavior when the organizational context also supports the behavior.

Finally, the relationship between access to means and problematic behavior would seem to be the clearest. In our model, even if someone has the propensity to perform a behavior and the behavior is disinhibited, the person could not perform the behavior without access to the means to do so. For example, a service member who was predisposed to abuse drugs and whose situation did not inhibit abusing drugs could not abuse drugs if drugs were not available.

¹⁷⁸ Ajzen and Fishbein, 1977.

Identifying Common Prevention Interventions for the Six Problematic Behaviors

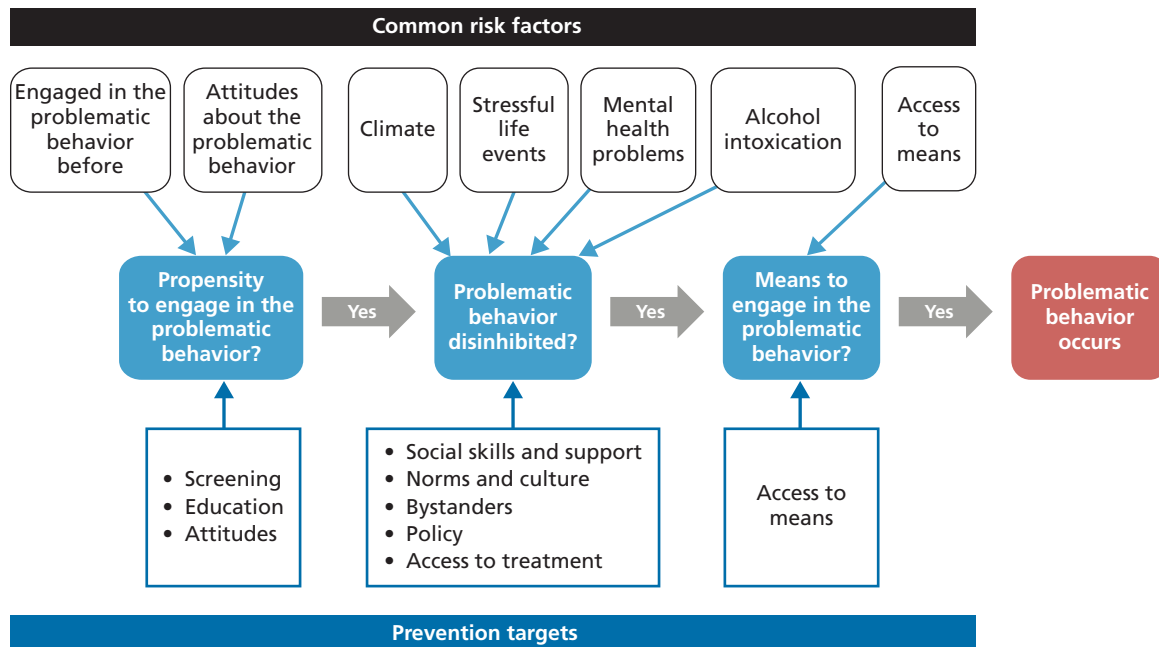
Having identified the common risk factors related to the six problematic behaviors, we now turn to identifying common effective prevention interventions across them. To accomplish this task, we reviewed the evidence supporting different prevention strategies for each problematic behavior. As with the review of literature on risk factors for these behaviors, we tried to focus on programs with strong, empirical evidence supporting the strategy. Our review included only programs or strategies that have been evaluated and for which the results of the evaluation have been publicly released. Thus, we exclude many promising but unevaluated programs from this review (e.g., the Army Sexual Harassment/Assault Response and Prevention [SHARP] program).

In an effort to identify prevention strategies that might translate to military settings, we placed restrictions on the strategies selected for review. We restricted our review to prevention strategies that had been implemented and evaluated in organizations rather than in controlled clinic settings. Where possible, we focused on strategies that had been used in settings and with populations that are similar to those of the military in certain respects (e.g., college students with respect to average age and racial and ethnic diversity). Finally, we prioritized evidence from experimental or quasi-experimental trials when available. Because evaluations for prevention efforts for some behaviors are limited, deviations from these restrictions were sometimes necessary to provide a full picture of prevention strategies. We note in the text any deviations.

Prevention-Strategy Selection and Linkage to the Conceptual Model

Figure 3.1 superimposes a conceptual structure by which to consider prevention efforts on our model for identified risk factors for problematic behavior. As the figure shows, leaders and policymakers who wish to implement prevention strategies have multiple stages at which to intervene, highlighting the potential for the development of a comprehensive approach to prevention planning. In stage 1, policymakers might wish to implement screening strategies to prevent people with a propensity toward problematic behavior from entering the organization. Alternatively, they might consider educational, policy, or climate interventions to reduce permissive attitudes about the problematic behavior. Although these prevention efforts might not be entirely successful, the model highlights that there is a second and third chance to intervene and prevent the behavior from emerging. Second-stage efforts might target those life events or circumstances that serve to disinhibit problematic behavior (e.g., binge drinking, untreated mental health problems). Finally, even if these strategies fail, means restriction provides a final chance to prevent the behavior from emerging. For example, efforts to prevent people with

Figure 3.1
Strategy Selection and Linkage to the Conceptual Model



RAND RR1352-3.1

gender biases from taking leadership roles (i.e., means to discriminate) or to reduce the number of prescriptions for opioid pain medications (i.e., means to develop substance-abuse problems) could successfully reduce the prevalence of problematic behavior.

Assessing Prevention Strategies for Addressing the Six Problematic Behaviors

In assessing the prevention strategies for addressing the six problematic behaviors, we used the model shown in Figure 3.1 and organized the strategies around the three prevention intervention points shown in the figure that correspond with the paths in the middle of the figure. Table 3.1 summarizes the results of the assessment, with an x representing prevention approaches that have been implemented and evaluated (whether or not they were shown to be effective). The type of implemented prevention strategies, and the quality of the research evidence to support them, varied across problematic behaviors. The fact that a prevention strategy has not been tested for a specific problematic behavior does not mean that the strategy would not effectively address the behavior. It simply means that that strategy has not been used for the behavior or that the strategy has not yet been empirically evaluated.

Our review showed that few strategies have been empirically tested for hazing and sexual harassment, but many strategies have been tested for suicide and substance abuse. In addition, many prevention programs implement more than one technique (e.g., an educational component and a social-skill component), which makes determining the effectiveness of some individual strategies difficult. Nonetheless, it is clear that some prevention strategies have been used across more of the problematic behaviors than others. Not surprisingly, education strate-

Table 3.1
Cross Between Problematic Behaviors and Prevention Strategies

| Prevention Strategy | Sexual Harassment | Sexual Assault | Unlawful Discrimination | Substance Abuse | Suicide | Hazing |
|--|-------------------|----------------|-------------------------|-----------------|---------|--------|
| Propensity to engage in behavior | | | | | | |
| Attitudes toward behavior | | x | x | x | x | |
| Education | x | x | x | x | x | x |
| Screening | | | | x | x | |
| Problematic behavior disinhibited | | | | | | |
| Norms and culture | | x | x | x | x | |
| Bystanders | | x | x | | x | |
| Social skills and support | | x | x | x | x | |
| Access to mental health treatment | | | | | x | |
| Policy | | x | | | | |
| Access to engage in problematic behavior | | | | | | |
| Access to means | | | x | x | x | |

gies have been used for all the behaviors, but the effectiveness of this strategy in reducing problematic behavior is not always clear. Strategies focused on intervening using attitude change, climate, or social-norm change or increasing social skills or social support have been used to address sexual assault, discrimination, substance abuse, and suicide. Other strategies have been less widely used (which might or might not be appropriate). In the rest of this chapter, we provide detail for the findings in Table 3.1, focusing the discussion on specific programs as applicable. The scope, activities, and targets of the identified prevention strategies varied considerably across problematic behaviors; the descriptions of identified programs follow and provide this detail.

Strategies for Preventing Sexual Harassment

As shown in Table 3.1, the only proactive sexual harassment prevention strategy that has been evaluated and published in the academic literature is sexual harassment awareness training.¹ The goals of these programs are to increase recognition of sexual harassment and provide guidance for how to handle complaints.² The programs also serve to “offer the necessary coverage to organizations in the event of sexual harassment cases.”³ There is some evidence that these programs increase the likelihood that participants will label sexually harassing behavior as

¹ Afroditi Pina, Theresa A. Gannon, and Benjamin Saunders, “An Overview of the Literature on Sexual Harassment: Perpetrator, Theory, and Treatment Issues,” *Aggression and Violent Behavior*, Vol. 14, No. 2, March–April 2009, pp. 126–138.

² Tamara Penix Sbraga and William O’Donohue, “Sexual Harassment,” *Annual Review of Sex Research*, Vol. 11, No. 1, 2000, pp. 258–285.

³ Pina, Gannon, and Saunders, 2009, p. 134.

sexual harassment.⁴ However, with respect to changes in actual sexually harassing behavior, a recent review of the literature notes that a rigorous evaluation of these programs that measure this outcome has yet to be conducted.⁵ Thus, it is unclear whether sexual harassment training actually reduces sexually harassing behaviors.

The literature reviewed in Chapter Two identified such factors as individuals' attitudes, perceptions of power, and organizational climate as important predictors of sexual harassment. However, sexual harassment awareness training targets only the recognition of sexually harassing behaviors. The focus on awareness ignores the "essential issues that surround the occurrence of [sexual harassment], such as sexism at work, power misuse and abuse, hierarchical issues, gendered environments, and individual perpetrator characteristics."⁶ Although sexual harassment recognition is a very important issue for organizations and employees, prevention programs might need to focus on individual, social, and structural factors related to sexual harassment to effectively address sexually harassing behaviors.⁷

Strategies for Preventing Sexual Assault

Since the DoD SAPRO was created in 2005, DoD and the services have invested considerable resources in implementing universal sexual assault prevention programs. Efforts to evaluate these programs are under way,⁸ but, at this date, little is known about the effectiveness of military-specific sexual assault prevention programs. However, some insight can be gleaned from program evaluations of sexual assault prevention efforts with civilian populations. Again, university settings provide a useful comparison, because the high density of young adults partially matches the demographic profile of the junior enlisted personnel who are at highest risk of being victims of sexual assault.⁹

In 1992, an amendment to the Campus Security Act required that all colleges and universities receiving federal funding implement a sexual assault prevention program.¹⁰ Given this requirement, prevention programs have been implemented almost universally in higher-education settings. These programs are typically educational in format. They are delivered in small-group settings, and a moderator provides definitions of sexual consent and sexual assault, information about reporting procedures, and possible criminal and campus disciplinary actions. Some curricula also include activities designed to increase empathy for sexual assault victims and to dispel myths and rape-supportive attitudes (e.g., "rape is trivial," "victims rather than perpetrators are responsible for victimization"). In a 2005 meta-analysis,

⁴ Heather Antecol and Deborah Cobb-Clark, "Does Sexual Harassment Training Change Attitudes? A View from the Federal Level," *Social Science Quarterly*, Vol. 84, No. 4, December 2003, pp. 826–842; James M. Wilkerson, "The Impact of Job Level and Prior Training on Sexual Harassment Labeling and Remedy Choice," *Journal of Applied Social Psychology*, Vol. 29, No. 8, August 1999, pp. 1605–1623.

⁵ Pina, Gannon, and Saunders, 2009.

⁶ Pina, Gannon, and Saunders, 2009, p. 134.

⁷ Pina, Gannon, and Saunders, 2009.

⁸ SAPRO, *Department of Defense Annual Report on Sexual Assault in the Military: Fiscal Year 2012*, Vol. 1, Washington, D.C.: U.S. Department of Defense, April 2013a.

⁹ Lindsay Rock, *2012 Workplace and Gender Relations Survey of Active Duty Members*, Alexandria, Va.: Defense Manpower Data Center, DMDC-2013-007, March 15, 2013.

¹⁰ Public Law 101-542, Student Right-to-Know and Campus Security Act, November 8, 1990; Public Law 102-325, Higher Education Amendments of 1992, July 23, 1992.

Anderson and Whiston, 2005, the authors reported disappointingly small effects of these prevention programs in terms of sexual violence incidence.¹¹ Although these programs have been somewhat successful in reducing rape-supportive attitudes, longitudinal research shows that these attitude improvements are transient and revert to preprogram levels within months of program completion.¹²

Given congressional mandates that rape-prevention programs be implemented, many campuses continue to offer these educational sessions, despite indications of limited utility. Others have begun to invest in novel and innovative approaches. One example is Bystander Intervention, a training program designed to encourage peers to intervene safely to prevent a potential assault from occurring (e.g., speaking up when a friend tries to lead an intoxicated woman away from a party).¹³ Although programs that rely on bystander approaches to sexual assault prevention have begun to be widely disseminated, there is not strong evidence to support their effectiveness.¹⁴ A meta-analysis of bystander-education programs identified 12 experimental or quasi-experimental evaluations of bystander-education programs for college students conducted between 1997 and 2011.¹⁵ The authors concluded that, although the program increases participants' self-reports that they would help someone at risk, it does not reduce the likelihood of sexual assault.¹⁶

As of 2014, no off-the-shelf prevention program has strong evidence to support its effectiveness *and* represents a good fit for the military population. Researchers at CDC recently conducted a high-quality systematic review of prevention strategies for sexual violence perpetration.¹⁷ They identified only three programs that have demonstrated effects on sexual assault perpetration in a rigorous¹⁸ outcome evaluation. Two of the effective prevention programs were designed for adolescents and were evaluated with this age group only (sixth- to ninth-graders), and the third was a comprehensive national funding program on the order of \$1.6 billion. Although applicability to the military appears limited, we review them for completeness next.

¹¹ Linda A. Anderson and Susan C. Whiston, "Sexual Assault Education Programs: A Meta-Analytic Examination of Their Effectiveness," *Psychology of Women Quarterly*, Vol. 29, No. 4, December 2005, pp. 374–388.

¹² Leanne R. Brecklin and David R. Forde, "A Meta-Analysis of Rape Education Programs," *Violence and Victims*, Vol. 16, No. 3, June 2001, pp. 303–321; Tracy L. Davis and Debora L. Liddell, "Getting Inside the House: The Effectiveness of a Rape Prevention Program for College Fraternity Men," *Journal of College Student Development*, Vol. 43, No. 1, January–February 2002, pp. 35–50.

¹³ Victoria L. Banyard, Elizabethe G. Plante, and Mary M. Moynihan, "Bystander Education: Bringing a Broader Community Perspective to Sexual Violence Prevention," *Journal of Community Psychology*, Vol. 32, No. 1, 2004, pp. 61–79.

¹⁴ Sarah DeGue, Linda Anne Valle, Melissa K. Holt, Greta M. Massetti, Jennifer L. Matjasko, and Andra Teten Tharp, "A Systematic Review of Primary Prevention Strategies for Sexual Violence Perpetration," *Aggression and Violent Behavior*, Vol. 19, No. 4, July–August 2014, pp. 346–362; Jennifer Katz and Jessica Moore, "Bystander Education Training for Campus Sexual Assault Prevention: An Initial Meta-Analysis," *Violence and Victims*, Vol. 28, No. 6, 2013, pp. 1054–1067.

¹⁵ J. Katz and Moore, 2013.

¹⁶ J. Katz and Moore, 2013.

¹⁷ DeGue et al., 2014.

¹⁸ Rigorous evaluations were defined as those with random assignment to an intervention or control condition (e.g., randomized controlled trial) or quasi-experimental designs (e.g., interrupted time series or regression discontinuity) when random assignment was not possible (DeGue et al., 2014).

Safe Dates

The Safe Dates program is a ten-session educational curriculum for eighth- and ninth-graders designed to improve conflict-management skills within dating relationships and to shift the social norms of the school to increase peer-based social sanctions for abusive dating behaviors.¹⁹ The program was evaluated in rural North Carolina schools with 14 matched public schools randomly assigned to the intervention or to a control condition. Follow-up data were collected annually for four years following program completion and showed that students who received the intervention were less likely to perpetrate sexual violence at all follow-up time points.²⁰ Sexual violence was measured dichotomously as a negative or positive response to a question assessing whether the student had forced “someone to have sex or do something else sexual that the partner did not want to do.” To our knowledge, this program has not been modified and evaluated for older adolescents or adults.

Shifting Boundaries

The Shifting Boundaries program included two components (classroom and building levels), but the evaluation revealed that only the building-level component effectively prevented sexual assault perpetration.²¹ The building-level intervention had three elements: (1) All students signed an agreement to respect one another’s boundaries; (2) staff hung posters in school buildings designed to increase awareness of sexual assault and provide resources for reporting; and (3) students completed a mapping exercise to identify areas on their school campus that they perceived as risky. School administrators used these maps to plan for increased surveillance by faculty and security staff. The evaluation included 30 public middle schools in New York City, which consisted of 117 classrooms and 2,655 sixth- and seventh-grade students. Stratified random assignment was used to assign classroom- and building-level interventions (or control). For middle school students assigned to the building intervention, there was a 47-percent reduction in the probability of perpetrating a sexual assault (compared with those who did not receive the intervention).²² Given the distribution of sexual assaults in this age group, the sexual assault measure included sexual contact assaults only (e.g., unwanted touching of private parts).

1994 Violence Against Women Act Funding

Since the passage of the Violence Against Women Act (VAWA),²³ more than \$1.6 billion has been allocated to research and community programs designed to reduce gender-related violence.²⁴ In 2009, 15 years after the passage of the act, Boba and Lilley published an evaluation of the effect of this funding. Relying on Uniform Crime Reporting data from the Fed-

¹⁹ Vangie A. Foshee, Karl E. Bauman, Susan T. Ennett, Chirayath Suchindran, Thad Benefield, and G. Fletcher Linder, “Assessing the Effects of the Dating Violence Prevention Program ‘Safe Dates’ Using Random Coefficient Regression Modeling,” *Prevention Science*, Vol. 6, No. 3, September 2005, pp. 245–258.

²⁰ Foshee et al., 2005.

²¹ Bruce G. Taylor, Nan D. Stein, Elizabeth A. Mumford, and Daniel Woods, “Shifting Boundaries: An Experimental Evaluation of a Dating Violence Prevention Program in Middle Schools,” *Prevention Science*, Vol. 14, No. 1, February 2013, pp. 64–76.

²² Taylor et al., 2013.

²³ Public Law 103-322, Violent Crime Control and Law Enforcement Act of 1994, September 13, 1994, Title IV.

²⁴ Angela M. Moore Parmley, “Violence Against Women Research Post VAWA: Where Have We Been, Where Are We Going?” *Violence Against Women*, Vol. 10, No. 12, December 2004, pp. 1417–1430.

eral Bureau of Investigation, the researchers analyzed changes in the prevalence of rape and sexual assault in communities that received VAWA funding. Controlling for prevalence of other crimes in the community, grant funding from other major federal programs to address crime, and community demographics and employment data, the authors found that receipt of VAWA funding was associated with a reduced prevalence of rape.²⁵ The regression model estimated that each 1-percent increase in funding predicted a 0.1-percent reduction in rapes. Given that the type of program or response to violence against women varied across communities, the analysis did not support comments on the specific programs or program components that were efficacious in preventing sexual assault.

Strategies for Preventing Unlawful Discrimination

As shown in Table 3.1, discrimination-prevention strategies have been implemented and evaluated in some form in all areas other than screening and access to mental health treatment. Several intervention strategies to prevent discrimination have been developed, and these interventions have mostly been implemented on a small scale in limited time frames.²⁶ Furthermore, only a few of these interventions have undergone rigorous evaluations to determine their effectiveness and applicability to populations like that of the military.²⁷ For example, although diversity training is widely used in private and public organizations, these initiatives have not been rigorously evaluated using randomized designs.²⁸ However, a review of the correlates of diversity training programs in 708 organizations found that, compared with organizations without diversity training, these initiatives were not associated with increases in organizational diversity.²⁹ In fact, compared with organizations without diversity training, advancement opportunities for black men and women declined over time in organizations with diversity training initiatives.³⁰

Other strategies to prevent discrimination have received more support, although the applicability of these interventions to a military context is unclear. For example, many of these interventions have been developed for children and adolescents and tested in school contexts, and there is a lack of rigorously tested intervention strategies for adults.³¹ Of course, it is unclear how well programs that target children and adolescents will translate to military contexts, but, in this section, we review intervention strategies that have been used with both children and adults. We also discuss possible complications in applying the strategies to a military context.

The Anti-Defamation League Peer Training Program uses a bystander-intervention paradigm with peer trainers who coach others in their organizations on effectively responding to

²⁵ R. Boba and D. Lilley, "Violence Against Women Act (VAWA) Funding: A Nationwide Assessment of Effects on Rape and Assault," *Violence Against Women*, Vol. 15, No. 2, February 2009, pp. 168–185.

²⁶ Elizabeth Levy Paluck and Donald P. Green, "Prejudice Reduction: What Works? A Review and Assessment of Research and Practice," *Annual Review of Psychology*, Vol. 60, January 2009, pp. 339–367.

²⁷ Paluck and Green, 2009.

²⁸ Elizabeth Levy Paluck, "Interventions Aimed at the Reduction of Prejudice and Conflict," in Linda R. Tropp, ed., *The Oxford Handbook of Intergroup Conflict*, Oxford: Oxford University Press, 2012, pp. 179–192.

²⁹ Alexandra Kalev, Frank Dobbin, and Erin Kelly, "Best Practices or Best Guesses? Assessing the Efficacy of Corporate Affirmative Action and Diversity Policies," *American Sociological Review*, Vol. 71, No. 4, August 2006, pp. 589–617.

³⁰ Kalev, Dobbin, and Kelly, 2006.

³¹ Paluck, 2012.

prejudice and discrimination.³² Peer trainers are taught empathy for others, critical thinking skills, and a sense of social responsibility, along with skills for effectively responding to prejudice and discrimination by their peers. They are also taught to facilitate workshops to help their peers understand and address discrimination when they see it occurring.³³ A randomized controlled trial (RCT) among high school students that tested the intervention against a control group demonstrated that it is effective at increasing awareness of discrimination, decreasing prejudicial attitudes, and increasing bystander intervention to correct prejudicial behavior (e.g., negative comments about black people).³⁴ Other bystander-intervention models have also been found to be effective in increasing bystander intervention to correct prejudicial behaviors, but this intervention technique to reduce discrimination remains largely untapped.³⁵ Note that the goal of these interventions is to increase the likelihood that bystanders will confront prejudicial or discriminatory behaviors when they encounter them.³⁶ It is unclear whether increasing antidiscrimination bystander intervention in an organization would also decrease discriminatory behavior.

Another new intervention used a social-network approach to change social norms of discrimination and harassment among high school students.³⁷ This intervention is unique: Because it focused on preventing harassing behaviors, it could be used to address both discriminatory behaviors and sexual harassment. However, the stated purpose of the intervention was to prevent harassment of minority groups based on such qualities as race and sexual orientation.³⁸ The goal of the intervention was to change students' perceptions of the school's social norms about the acceptability of harassing behaviors among peers. Social-network techniques were used to find the people who were central to school social networks (i.e., the social referents), and those people were recruited to take part in the intervention. The intervention entailed having these people publicly disclose their experiences being the targets of prejudice or harassment and how it affected them. Results showed that, compared with a control group, students exposed to the intervention were less likely to engage in harassing behaviors, as reported by teachers and in disciplinary records.³⁹

Another set of interventions to prevent discrimination is based on the idea that contact with minority-group members under specific conditions will decrease prejudice and discrimination. These interventions are known as structured direct contact or cooperative learning programs, and they involve having members from majority and minority groups interact in a situation in which they cooperate together on a task, in which members of each social group

³² Elizabeth Levy Paluck, "Peer Pressure Against Prejudice: A High School Field Experiment Examining Social Network Change," *Journal of Experimental Social Psychology*, Vol. 47, No. 2, March 2011, pp. 350–358.

³³ Paluck, 2011.

³⁴ Paluck, 2011.

³⁵ For a review, see Jacqueline K. Nelson, Kevin M. Dunn, and Yin Paradies, "Bystander Anti-Racism: A Review of the Literature," *Analyses of Social Issues and Public Policy*, Vol. 11, No. 1, December 2011, pp. 263–284.

³⁶ J. Nelson, Dunn, and Paradies, 2011.

³⁷ Elizabeth Levy Paluck and Hana Shepherd, "The Salience of Social Referents: A Field Experiment on Collective Norms and Harassment Behavior in a School Social Network," *Journal of Personality and Social Psychology*, Vol. 103, No. 6, December 2012, pp. 899–915.

³⁸ Paluck and Shepherd, 2012.

³⁹ Paluck and Shepherd, 2012.

have equal status, and in which there is support for intergroup contact from authorities.⁴⁰ A meta-analysis of 515 studies testing this intervention among children, adolescents, and adults found that the technique is effective in reducing prejudice toward minority groups, even when certain conditions, such as equal status and support from authorities, are not met.⁴¹ A recent meta-analysis of 122 experimental studies of cooperative-learning interventions among children and adolescents found that those programs designed to promote empathy and perspective-taking had the largest impact on both prejudicial attitudes and behaviors.⁴² It is unclear how well these interventions would translate to a military context. Indeed, many scholars see the military as already embodying many of the qualities of ideal contact between majority and minority groups (e.g., equal status, cooperation on tasks, support from authorities),⁴³ so the military might already experience better racial relations than civilian organizations do. Of course, the military is not monolithic, and race relations are not necessarily equal across units or services,⁴⁴ so more-structured contact-based interventions might be useful for decreasing discrimination in some units.

Finally, organizational interventions have been shown to be effective in decreasing discriminatory job practices. Formalized organizational procedures reduce discriminatory work practices by limiting the influence that people's biases can have on organizational decisions.⁴⁵ Formalized organizational procedures are associated with less bias in performance evaluations,⁴⁶ salary levels,⁴⁷ and promotion rates.⁴⁸ The military is often considered a model of how organizational practices should be designed to reduce prejudice. That said, some have recommended that military procedures be adjusted to reduce racial bias in promotion rates and reduce disparities in sentencing within the military justice system.⁴⁹

Strategies for Preventing Substance Abuse

As shown in Table 3.1, substance-abuse prevention programs have been implemented and tested in all categories except for bystander intervention and access to mental health treatment. Several meta-analysis studies have been conducted on substance-abuse prevention programs.⁵⁰ Drawing on this body of meta-analytic studies, we highlight in this section key findings about

⁴⁰ Paluck and Green, 2009.

⁴¹ Pettigrew and Tropp, 2006.

⁴² Andreas Beelmann and Kim Sarah Heinemann, "Preventing Prejudice and Improving Intergroup Attitudes: A Meta-Analysis of Child and Adolescent Training Programs," *Journal of Applied Developmental Psychology*, Vol. 35, No. 1, January–February 2014, pp. 10–24.

⁴³ Mershon and Schlossman, 1998; Moskos and Butler, 1996.

⁴⁴ Burk and Espinoza, 2012.

⁴⁵ Pager and Shepherd, 2008.

⁴⁶ Krieger, 1995; Reskin, 2000.

⁴⁷ Elvira and Graham, 2002.

⁴⁸ Stainback, Tomaskovic-Devey, and Skaggs, 2010.

⁴⁹ Burk and Espinoza, 2012.

⁵⁰ Irwin Sandler, Sharlene A. Wolchik, Gracelyn Cruden, Nicole E. Mahrer, Soyeon Ahn, Ahnalee Brincks, and C. Hendricks Brown, "Overview of Meta-Analyses of the Prevention of Mental Health, Substance Use, and Conduct Problems," *Annual Review of Clinical Psychology*, Vol. 10, 2014, pp. 243–273.

effective substance-abuse prevention strategies. When relevant, we incorporate findings from other types of systematic reviews.

Alcohol Misuse Prevention in College Students

Some meta-analysis studies focus on alcohol misuse prevention programs for college students.⁵¹ The prevention programs employed RCT and nonequivalent control-group designs and included participants whose ages ranged between 17 and 26.⁵² One meta-analysis that included 62 studies of brief (median of two sessions) individual-level programs encompassing a variety of strategies (e.g., motivational interviewing, normative comparison, education on blood alcohol content, and feedback on personal alcohol use) found small significant effects on the frequency of drinking and alcohol-related problems that diminished over time but remained significant up to four years postintervention.⁵³ At short-term follow-up, program effects were greater for interventions that included motivational interviewing, normative feedback, decisional balance exercise (weighing the costs and benefits of changing alcohol use behaviors), and feedback on alcohol expectancies or motivations for drinking than they were for those that did not.⁵⁴

Another meta-analysis examined the effects of the Brief Alcohol Screening and Intervention for College Students program, which consists of motivational interviewing and personalized feedback on alcohol use behaviors typically delivered in one or two structured sessions.⁵⁵ Effects on alcohol consumption were derived from 12 RCTs, and effects on alcohol-related problems were based on 11 RCTs. At 12-month follow-up, large significant effects for decreases in alcohol consumption and alcohol-related problems were found among college students with heavy alcohol use compared with counterparts in control conditions.⁵⁶

With respect to programs targeting alcohol expectancies, a meta-analysis of 14 studies found significant small effects, which were no longer significant at follow-ups occurring a month or more after the intervention.⁵⁷

A meta-analysis comparing face-to-face and computer-delivered prevention programs found that participants who received face-to-face interventions exhibited significantly greater decreases in alcohol use and alcohol-related problems at short-term follow-up, with effects on reduced alcohol use persisting at longer-term follow-up.⁵⁸

⁵¹ Sandler et al., 2014.

⁵² Sandler et al., 2014.

⁵³ Kate B. Carey, Lori A. J. Scott-Sheldon, Michael P. Carey, and Kelly S. DeMartini, "Individual-Level Interventions to Reduce College Student Drinking: A Meta-Analytic Review," *Addictive Behaviors*, Vol. 32, No. 11, November 2007, pp. 2469–2494.

⁵⁴ Carey, Scott-Sheldon, Carey, et al., 2007.

⁵⁵ Alexandre Fachini, Poliana P. Aliane, Edson Z. Martinez, and Erikson F. Furtado, "Efficacy of Brief Alcohol Screening Intervention for College Students (BASICS): A Meta-Analysis of Randomized Controlled Trials," *Substance Abuse Treatment, Prevention, and Policy*, Vol. 7, 2012, p. 40.

⁵⁶ Fachini et al., 2012.

⁵⁷ Lori A. J. Scott-Sheldon, Danielle L. Terry, Kate B. Carey, Lorra Garey, and Michael P. Carey, "Efficacy of Expectancy Challenge Interventions to Reduce College Student Drinking: A Meta-Analytic Review," *Psychology of Addictive Behaviors*, Vol. 26, No. 3, September 2012, pp. 393–405.

⁵⁸ Kate B. Carey, Lori A. J. Scott-Sheldon, Jennifer C. Elliott, Lorra Garey, and Michael P. Carey, "Face-to-Face Versus Computer-Delivered Alcohol Interventions for College Drinkers: A Meta-Analytic Review, 1998 to 2010," *Clinical Psychology Review*, Vol. 32, No. 8, December 2012, pp. 690–703.

Finally, a recent meta-analysis investigated the effects of providing social-norm information across different mechanisms (i.e., mailed feedback, web or computer feedback, individual versus group face-to-face feedback, general social-norm marketing campaigns) to college students.⁵⁹ Of the 66 studies included in the review, 39 targeted higher-risk students (i.e., screened positive on risky drinking test, mandated to receive intervention because of behavior and college rules), and 52 studies were conducted in the United States. At four or more months at follow-up, web feedback and individual face-to-face feedback yielded small effects for alcohol-related problems, binge-drinking quantity, frequency of alcohol consumption, and blood alcohol concentration levels. Mailed feedback and group face-to-face feedback demonstrated no significant effects for alcohol-related problems. Social marketing campaigns also did not exhibit significant effects on frequency of alcohol consumption or blood alcohol concentration levels. Despite the significant small effects observed, the authors concluded that, given the measurement scales employed in the studies, these effects are too small to be policy- or practice-relevant.⁶⁰

Illicit-Drug Use

Meta-analysis studies investigating the effects that prevention programs have on illicit-drug use are made up primarily of school-based interventions. Faggiano and colleagues examined 29 RCT studies, mostly focused on sixth- and seventh-grade students. Skill-based programs yielded small significant effects on lowering marijuana and other drug use. In contrast, affect-focused interventions—for example, self-esteem— or self-awareness—building interventions that are based on the assumption that psychological factors place people at risk of use—had a significant impact on only decisionmaking skills and drug knowledge, while knowledge-focused programs had an effect only on drug knowledge.⁶¹ A meta-analysis of 15 studies on marijuana use—prevention programs among youths age 12 to 19 found significant moderate effects on diminishing marijuana use.⁶² Larger effect sizes were observed for programs that incorporated multiple components (e.g., affective, informational, social-learning models), longer intervention duration (15 or more sessions), leaders other than teachers, fidelity checks, and interactive (versus didactic) elements. Another meta-analysis conducted with 12 school-based programs found small significant effects for reduced marijuana and other drug use at both short-term (less than one year) and longer-term follow-up.⁶³ In a comprehensive meta-analytic review of 207 studies, Tobler and colleagues found significantly greater reductions in drug use at one- to 12-month follow-up for interactive prevention programs (e.g., interpersonal-skill training) than for noninteractive programs (e.g., lecture-oriented with an emphasis on drug knowledge

⁵⁹ David R. Foxcroft, Maria Teresa Moreira, Nerissa M. L. Almeida Santimano, and Lesley A. Smith, “Social Norms Information for Alcohol Misuse in University and College Students,” *Cochrane Database of Systematic Reviews*, Vol. 12, 2015, Art. CD006748.

⁶⁰ Foxcroft et al., 2015.

⁶¹ Fabrizio Faggiano, Federica Vigna-Taglianti, Elisabetta Versino, Alessio Zambon, Alberto Borraccino, and Patrizia Lemma, “School-Based Prevention for Illicit Drugs’ Use,” *Preventive Medicine*, Vol. 46, No. 5, May 2008, pp. 385–396.

⁶² Amy J. Porath-Waller, Erin Beasley, and Douglas J. Beirness, “A Meta-Analytic Review of School-Based Prevention for Cannabis Use,” *Health Education and Behavior*, Vol. 37, No. 5, October 2010, pp. 709–723.

⁶³ David W. Soole, Lorraine Mazerolle, and Sacha Rombouts, “School-Based Drug Prevention Programs: A Review of What Works,” *Australian and New Zealand Journal of Criminology*, Vol. 41, No. 2, August 2008, pp. 259–286.

or affective development).⁶⁴ Finally, programs led by peers yielded greater effects than teacher-led programs on reducing drug use, according to findings from two meta-analysis studies.⁶⁵

Environmental and Means Restriction

In a meta-analysis involving 112 studies of alcohol tax or pricing effects, significant reductions in alcohol sales, alcohol consumption, and heavy drinking were observed.⁶⁶ Although not based entirely on evidence drawn from meta-analytic studies, an IOM report on SUDs in the U.S. armed forces identified four environmental policy strategies that could be applied to alcohol use and related problems in the military population.⁶⁷ The strategies include targeting the affordability through pricing and taxation, limiting the availability (e.g., enforcement of legal drinking age), modifying the context of alcohol use (e.g., training bar staff or liquor retailers in responsible beverage service), and preventing driving while intoxicated (e.g., drinking-and-driving policies, traffic checkpoints).⁶⁸

Military Prevention Programs

The IOM 2013 report on SUDs in the U.S. armed forces highlighted a multicomponent intervention delivered to the Air Force. The New Orientation to Reduce Threats to Health from Secretive Problems That Affect Readiness program employs a community-based approach that targets substance-use problems, suicide, and family maltreatment.⁶⁹ Commanders and providers, in partnership with the Air Force community action information boards (CAIBs), select evidence-based programs that match the specific risk and protective factor profiles of their respective populations. The IOM report identifies New Orientation to Reduce Threats to Health from Secretive Problems That Affect Readiness as a promising program and notes that an RCT involving 24 Air Force bases with more than 50,000 active-duty service members found effects for lowered levels of alcohol abuse and prescription drug abuse.⁷⁰

Strategies for Preventing Suicide

As shown in Table 3.1, prevention programs for suicide have been implemented and tested in all areas other than policy changes. Some reviews of suicide prevention strategies have been conducted.⁷¹ Numerous challenges to evaluating the effectiveness of suicide prevention pro-

⁶⁴ Nancy S. Tobler, Michael R. Roona, Peter Ochshorn, Diana G. Marshall, Andrei V. Streke, and Kimberly M. Stackpole, "School-Based Adolescent Drug Prevention Programs: 1998 Meta-Analysis," *Journal of Primary Prevention*, Vol. 20, No. 4, June 2000, pp. 275–336.

⁶⁵ Pim Cuijpers, "Effective Ingredients of School-Based Drug Prevention Programs: A Systematic Review," *Addictive Behaviors*, Vol. 27, No. 6, November–December 2002, pp. 1009–1023; Denise C. Gottfredson and David B. Wilson, "Characteristics of Effective School-Based Substance Abuse Prevention," *Prevention Science*, Vol. 4, No. 1, March 2003, pp. 27–38.

⁶⁶ Wagenaar, Salois, and Kimro, 2009.

⁶⁷ IOM, 2013.

⁶⁸ IOM, 2013.

⁶⁹ IOM, 2013.

⁷⁰ IOM, 2013.

⁷¹ Goldsmith et al., 2002; J. John Mann, Alan Apter, Jose Bertolote, Annette Beautrais, Dianne Currier, Ann Haas, Ulrich Hegerl, Jouko Lonnqvist, Kevin Malone, Andrej Marusic, Lars Mehlum, George Patton, Michael Phillips, Wolfgang Rutz, Zoltan Rihmer, Armin Schmidtke, David Shaffer, Morton Silverman, Yoshitomo Takahashi, Airi Varnik, Danuta Wasserman, Paul Yip, and Herbert Hendin, "Suicide Prevention Strategies: A Systematic Review," *Journal of the American*

grams have been documented. These include difficulties in detecting program effects given the low base rates of suicide, inconsistencies in how suicides are classified and tracked, and the use of proxies for deaths by suicide (e.g., suicidal ideation or attempts).⁷² Thus, only a few studies have been able to demonstrate a causal link between suicide prevention activities and decreases in suicides, leaving a rather limited evidence base to guide the identification of best practices for suicide prevention efforts.⁷³ Although it notes these challenges, a RAND report identified the suicide prevention strategies with the strongest available evidence base: school-based prevention programs that include skill-building, physician training to detect depression and assess suicide risk, use of effective treatment for depression and other mental health problems, integrated approaches across whole communities, and means restriction.⁷⁴ In this section, we provide a brief review of these suicide prevention strategies.

School-Based Prevention Programs with Skill-Building

One set of suicide prevention strategies has focused on “raising awareness and building skills” around suicide or other behavioral health issues, with the aim of increasing protective factors and minimizing risk factors.⁷⁵ Citing findings from a landmark IOM report,⁷⁶ Ramchand and his colleagues note that, although this educational awareness, skill-building approach has been evaluated mostly within the context of school-based programs, two programs have demonstrated reductions in suicidal behaviors.⁷⁷ The Signs of Suicide (SOS) program has been tested in high school populations⁷⁸ and more recently in junior high school students.⁷⁹ The SOS program trains students to respond to the signs and symptoms of suicide or depression, both in themselves and others, using a mnemonic, *ACT*. *A* reminds students to acknowledge the signs of suicide; *C* tells them to let the person know that they care and want to help; and *T* reminds them to tell a responsible adult.⁸⁰ High school students who had participated in the SOS program had significantly lower self-reported suicide attempts at three-month follow-up than control students did.⁸¹ The Army sponsors similar gatekeeper training programs—Ask, Care, Escort and Applied Suicide Intervention Skills Training—in which peers, health professionals, clergy, and officers are trained to recognize suicide risk and provide support, but no evaluations have been conducted focusing on reductions in suicide.⁸²

Medical Association, Vol. 294, No. 16, October 26, 2005, pp. 2064–2074; Ramchand et al., 2011; Denning, Meisnere, and Warner, 2014.

⁷² Goldsmith et al., 2002; Ramchand et al., 2011.

⁷³ Goldsmith et al., 2002; Mann et al., 2005; Ramchand et al., 2011.

⁷⁴ Ramchand et al., 2011.

⁷⁵ Ramchand et al., 2011, p. 43.

⁷⁶ Goldsmith et al., 2002.

⁷⁷ Ramchand et al., 2011.

⁷⁸ Robert H. Aseltine Jr., Amy James, Elizabeth A. Schilling, and Jaime Glanovsky, “Evaluating the SOS Suicide Prevention Program: A Replication and Extension,” *BMC Public Health*, Vol. 7, 2007, p. 161.

⁷⁹ E. A. Schilling, M. Lawless, L. Buchanan, and R. H. Aseltine Jr., “‘Signs of Suicide’ Shows Promise as a Middle School Suicide Prevention Program,” *Suicide and Life-Threatening Behavior*, Vol. 44, No. 6, December 2014, pp. 653–667.

⁸⁰ Aseltine et al., 2007.

⁸¹ Aseltine et al., 2007.

⁸² Denning, Meisnere, and Warner, 2014.

Another program developed for first- and second-grade students, the Good Behavior Game, which focuses on classroom behavior management, found significant reductions in suicidal ideation when this group reached ages 19 to 21.⁸³ In a review of school-based suicide prevention program, SOS and the Good Behavior Game were identified as the only programs demonstrating a significant reduction in the number of suicide attempts.⁸⁴

Physician Training to Screen for Depression and Assess Suicide Risk

Programs aimed at training general practitioners and primary-care physicians on identifying and treating depression have been associated with decreases in suicidal behaviors.⁸⁵ On the Swedish island of Gotland, an educational program on the symptoms, etiology, diagnosis, prevention, and treatment of depression was made available to all general practitioners from 1983 to 1984.⁸⁶ Compared with a baseline assessment administered in 1982, significant decreases in suicide rates, sick leave for depressive disorders, and inpatient care for depressive disorders were observed three years later.⁸⁷ Moreover, suicide rates nearly reached baseline levels in 1988, three years after the project ended.

Collaborative care programs that have focused on physician training in assessing and treating depression have also yielded positive outcomes.⁸⁸ Collaborative care programs often incorporate the role of a care facilitator or care manager who assists in coordinating care between primary-care physicians and behavioral health specialists. One collaborative care program targeting depression has been able to demonstrate reductions in suicidal ideation.⁸⁹ Ensuring access to quality mental health services and repeated screening, given the episodic nature of suicidal ideation and intent, have been underscored as essential components to any behavioral health screening or collaborative care effort.⁹⁰

⁸³ Sheppard G. Kellam, Amelia C. L. Mackenzie, C. Hendricks Brown, Jeanne M. Poduska, Wei Wang, Hanno Petras, and Holly C. Wilcox, "The Good Behavior Game and the Future of Prevention and Treatment," *Addiction Science and Clinical Practice*, Vol. 6, No. 1, July 2011, pp. 73–84.

⁸⁴ Cara Katz, Shay-Lee Bolton, Laurence Y. Katz, Corinne Isaak, Toni Tilston-Jones, Jitender Sareen, and Swampy Cree Suicide Prevention Team, "A Systematic Review of School-Based Suicide Prevention Programs," *Depression and Anxiety*, Vol. 30, No. 10, October 2013, pp. 1030–1045.

⁸⁵ Mann et al., 2005; Ramchand et al., 2011.

⁸⁶ W. Rutz, J. Wålinder, G. Eberhard, G. Holmberg, A.-L. von Knorring, L. von Knorring, B. Wistedt, and A. Åberg-Wistedt, "An Educational Program on Depressive Disorders for General Practitioners on Gotland: Background and Evaluation," *Acta Psychiatrica Scandinavica*, Vol. 79, No. 1, January 1989, pp. 19–26.

⁸⁷ Wolfgang Rutz, *Evaluation of an Educational Program on Depressive Disorders Given to General Practitioners on Gotland: Short and Long-Term Effects*, Linköping, Sweden: Linköping University, Department of Psychiatry, Faculty of Health Sciences, University Hospital, thesis, 1992.

⁸⁸ Janine Archer, Peter Bower, Simon Gilbody, Karina Lovell, David Richards, Linda Gask, Chris Dickens, and Peter Coventry, "Collaborative Care for Depression and Anxiety Problems," *Cochrane Database of Systematic Reviews*, No. 10, 2012, Art. CD006525.

⁸⁹ Jürgen Unützer, Wayne Katon, Christopher M. Callahan, John W. Williams Jr., Enid Hunkeler, Linda Harpole, Marc Hoffing, Richard D. Della Penna, Polly Hitchcock Noël, Elizabeth H. B. Lin, Patricia A. Areán, Mark T. Hegel, Lingqi Tang, Thomas R. Belin, Sabine Oishi, and Christopher Langston, "Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial," *Journal of the American Medical Association*, Vol. 288, No. 22, December 11, 2002, pp. 2836–2845.

⁹⁰ Goldsmith et al., 2002; Ramchand et al., 2011.

Use of Effective Treatment for Depression and Other Mental Health Problems

As indicated earlier, studies have documented that the majority of suicide deaths involve a history of mental health problems. Thus, access to quality behavioral health care is seen as an important suicide prevention strategy.⁹¹ In a review of suicide prevention efforts in the military, providing not only access but also continuity of care for behavioral health needs was identified as an essential prevention strategy given that a substantial proportion of people, in both the civilian and military populations, had contact with a mental health provider shortly before dying by suicide.⁹² Moreover, for people with a history of previous suicide attempts, dialectical behavior therapy and cognitive therapy have been found to decrease subsequent suicide attempts in civilian populations only, although studies are under way in the military population.⁹³

Integrated Community Approaches

Some programs have adopted a multicomponent community approach with a wide range of targets, including influencing public knowledge and attitudes toward suicide, enhancing access to quality mental health services, and implementing policies to restrict access to lethal means to suicide.⁹⁴ Such integrated community approaches have been implemented at the national, state, and tribal levels.⁹⁵ The Air Force developed and implemented a comprehensive suicide prevention program, which yielded significant reductions in suicide.⁹⁶ The Air Force Suicide Prevention Program consists of 11 initiatives directed at transforming perceptions of suicide as a medical problem to a community-wide problem, eliminating the stigma associated with behavioral health care, increasing mental health knowledge, and affecting social norms and policies that would promote behavioral health care utilization and mitigate the possible adverse consequences on one's career that could be incurred by seeking treatment.⁹⁷ Program components include leadership involvement in the entire spectrum of suicide prevention initiatives; suicide prevention education in all formal military training; guidelines for commanders' use of mental health services; annual suicide prevention training for all military and civilian employees in the Air Force; policies that stipulate suicidal risk assessment for people undergoing investigation for legal problems; increased confidentiality for people at risk for suicide who are seen by mental health providers; and the employment of surveillance tools to track a unit's strengths, vulnerabilities, and incidence of suicide events.⁹⁸

⁹¹ U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012; WHO, 2014.

⁹² Ramchand et al., 2011.

⁹³ Ramchand et al., 2011.

⁹⁴ Ramchand et al., 2011.

⁹⁵ Ramchand et al., 2011.

⁹⁶ Kerry L. Knox, David A. Litts, G. Wayne Talcott, Jill Catalano Feig, and Eric D. Caine, "Risk of Suicide and Related Adverse Outcomes After Exposure to a Suicide Prevention Programme in the US Air Force: Cohort Study," *BMJ*, Vol. 327, 2003, p. 1376.

⁹⁷ Denning, Meisnere, and Warner, 2014.

⁹⁸ Kerry L. Knox, Steven Pflanz, Gerald W. Talcott, Rick L. Campise, Jill E. Lavigne, Alina Bajorska, Xin Tu, and Eric D. Caine, "The US Air Force Suicide Prevention Program: Implications for Public Health Policy," *American Journal of Public Health*, Vol. 100, No. 12, December 2010, pp. 2457–2463.

Information on all Air Force active-duty suicides and suicide attempts is entered into a central database, the Suicide Event Surveillance System, that tracks suicide events and potential risk factors for suicide in Air Force personnel. According to Knox and colleagues, this approach has limitations, but the authors nevertheless recognized the importance of moving “beyond descriptive, epidemiologic studies of suicide risk” through the careful tracking of programmatic activities.⁹⁹

Means Restriction

In a systematic review conducted by international experts across 15 countries, restrictions to lethal means of suicide was identified as one of two strategies (the other being physician education) with a strong evidence base of reducing suicides.¹⁰⁰ Legislation aimed at restricting firearms, the prescription and sale of barbiturates, and access to jumping sites, higher-toxicity gases, and antidepressants have been associated with reduced suicides.¹⁰¹ For example, following a policy change in which the Israel Defense Forces restricted access to firearms, suicide rates were significantly reduced by 40 percent in the adolescent population.¹⁰² A recent IOM report on the prevention of psychological disorders in the military population notes the existence of DoD gun safety protocols for military-issued weapons but not for privately owned firearms in instances in which a service member might be at risk for suicide.¹⁰³

Strategies for Preventing Hazing

As shown Table 3.1, we identified hazing-prevention programs only in the education and training area. In response to recent congressional attention,¹⁰⁴ DoD has increased efforts to prevent hazing incidents and increase knowledge of hazing across the department. Currently, the services provide hazing-prevention training to the force, but that training is not standardized across DoD and has not been evaluated to date. Keller and colleagues recommend that DoD specify the desired outcomes of its hazing-prevention efforts and assess their effects.¹⁰⁵

Although training and education is the predominant hazing-prevention method being implemented both inside and outside of DoD, empirical research on its effectiveness is extremely limited. Two research efforts have conducted an assessment of hazing-prevention education programs, but both efforts had significant limitations.¹⁰⁶ We found no additional systematic evaluations of hazing-prevention efforts.

⁹⁹ Knox et al., 2010, p. 2461.

¹⁰⁰ Mann et al., 2005.

¹⁰¹ Mann et al., 2005.

¹⁰² G. Lubin, N. Werbeloff, D. Halperin, M. Shmushkevitch, M. Weiser, and H. Y. Knobler, “Decrease in Suicide Rates After a Change of Policy Reducing Access to Firearms in Adolescents: A Naturalistic Epidemiological Study,” *Suicide and Life-Threatening Behavior*, Vol. 40, No. 5, October 2010, pp. 421–424.

¹⁰³ Denning, Meisnere, and Warner, 2014.

¹⁰⁴ Pub. L. 112-239, 2013.

¹⁰⁵ Keller et al., 2015.

¹⁰⁶ Keller et al., 2015.

One research effort was an unpublished thesis evaluating the effects of a hazing-prevention training workshop.¹⁰⁷ A 1.5-hour educational session on hazing was delivered to 19 sports club officers at a midsize university. The session included instruction on the definition of hazing, hazing's prevalence, reasons hazing might occur, consequences of hazing, and alternatives to hazing. The intervention group was surveyed before and after receiving the training to assess changes in hazing knowledge and intentions to participate in hazing. A comparison group of 44 student athletes who did not receive the training were also surveyed. Hazing knowledge increased among program attendees, but there was no change in intentions to participate in hazing. However, limitations in measurement might have resulted in the lack of observed effects on intentions. For instance, prior to completing the workshop, participants were not likely to indicate strong support for hazing, so there was little room to observe improvements in intentions.

DeWitt and DeWitt conducted the second identified research effort, which involved a case study of an antihazing intervention that was implemented at a Michigan high school following a highly publicized hazing incident at the school.¹⁰⁸ A restorative justice plan was implemented that year for participants in the hazing incident that included education sessions, presentations to other students, and community service. Seven years later, the study authors conducted a survey of high school juniors from the school to assess the effects of the earlier intervention.¹⁰⁹ The authors suggested that the culture has changed at the high school since implementing this intervention, with few students indicating hazing participation and most understanding the definition of hazing and its consequences. However, the length of time between the program intervention and assessment and the multiple confounding variables involved contribute to uncertainty about the study results.

Summary

As noted previously, our review showed that few strategies have been empirically tested for hazing and sexual harassment, but many strategies have been tested for suicide and substance abuse. In addition, many prevention programs implement more than one technique (e.g., an educational component and a social-skill component), which makes determining the effectiveness of some individual strategies difficult. Nonetheless, it is clear that some prevention strategies have been used across more of the problematic behaviors than others. Not surprisingly, education strategies have been used for all the behaviors, but the effectiveness of this strategy in reducing problematic behavior is not always clear. Strategies focused on intervening using attitude change, climate or social-norm change, or increasing social skills have been used to address sexual assault, discrimination, substance abuse, and suicide.

¹⁰⁷ Anthony D. Capretto, *Hazing in Sport: Evaluation of an Educational Workshop*, Chico, Calif.: California State University, Chico, master's thesis, Summer 2011.

¹⁰⁸ Douglas M. DeWitt and Lori J. DeWitt, "A Case of High School Hazing: Applying Restorative Justice to Promote Organizational Learning," *NASSP Bulletin*, Vol. 96, No. 3, September 2012, pp. 228–242.

¹⁰⁹ DeWitt and DeWitt, 2012.

The Office of the Secretary of Defense's Strategic-Level Organization to Address Problematic Behavior

As noted in Chapter One, our study team took a two-pronged approach to the issue of integrating ways to address problematic behavior. Chapters Two and Three discuss the behavioral thrust of the research. This chapter discusses our programmatic research, which aimed to understand OSD's organization for dealing with the selected problematic behaviors. In particular, we sought to answer three questions:

- What OSD organizations are involved in addressing problematic behavior, and how are they structured?
- What coordination and oversight mechanisms are OSD organizations using?
- How well managed are OSD organizations to address problematic behavior?

In this chapter, our focus is on OSD organizations that have designated responsibility for the six problematic behaviors examined in this study. We identified these organizations through consultations with DoD officials and RAND researchers, as well as through information from DoD documents and websites. These organizations include the following:

- ODMEIO
- DSPO
- SAPRO
- the DDRP
- Office of the Assistant Secretary of Defense (ASD) for Health Affairs (ASD[HA])
- Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCCOE)
- Defense Health Agency (DHA).

To answer the three questions, we consulted primary and secondary sources for information. We studied DoDDs, strategic plans, and other formal DoD documentation directly related to these organizations and the six problematic behaviors. We also examined relevant RAND studies¹ and other academic and government publications that were either recommended by policy discussants or discovered via searches of electronic data sources, such as the Defense Technical Information Center. Complementing these secondary sources were semistructured discussions with DoD officials, many of whom were members of these organizations, as well as participants in the Joint Staff High-Risk Behavior Working Group. They gave us

¹ For example, our study team is drawing information from another RAND study for ODMEIO on hazing in the armed forces (Keller et al., 2015).

important insights into specialized issues in a complex organization, such as OSD.² Finally, we are grateful to those DoD officials who attended a half-day workshop we organized for OSD.³ The information they shared about their organizations and the subsequent exchanges among them helped us to appreciate critical issues in intra- and interorganizational collaboration to improve the management of programs to address problematic behavior at OSD.

The remainder of this chapter is divided into sections that address each of our first three programmatic research questions.

What Organizations Are Involved in Addressing Problematic Behavior, and How Are They Structured?

This section describes OSD organizations responsible for guiding, overseeing, informing, and coordinating efforts to address the problematic behavior under examination. It also focuses on how those organizations to address problematic behavior are structured in terms of leadership elements, major subordinate (line) organizations, and major coordinating bodies, as well as the connections among them—that is, lines of authority, formal coordinating relationships, and informal coordinating relationships. The short answer is that *the design of strategic-level organizations dealing with problematic behavior varies considerably*. In this section, we discuss the structure of these organizations, most of which fall under the purview of the USD(P&R), in more detail. As previously noted, we completed the research for this study in the fall of 2015. Since then, the structure of the USD(P&R) has continued to evolve—notably, through the elimination of the position of ASD for Readiness and Force Management (ASD[R&FM]) and its replacement by two ASD positions, one for manpower and reserve affairs and another for readiness; the creation of the position of executive director of the Office of Force Resiliency;⁴ and the placement of DCoE under the authority of the DHA. Given that the study team has not been able to ascertain the full scope and consequences of these changes, we have chosen to analyze the organizational situation that existed prior to October 2015.

Sexual Assault

Key Office of the Secretary of Defense Organization

Sexual assault is not a new problem, and DoD has long been clear that it will not be tolerated. A scandal at the U.S. Air Force Academy in 2003 raised the public profile of the problem and greatly increased media reporting on sexual assault in the military. In response, top DoD leaders convened special meetings and committees to determine extent of the problem and

² Appendix B presents the protocol that was used to guide policy discussions with DoD officials for programs to address problematic behavior.

³ Held on August 14, 2104, under the auspices of the military deputy to the USD(P&R), NDRI organized this workshop to obtain information on existing oversight and coordination mechanisms for programs to address problematic behavior and to discuss ways to improve it. Participating organizations included SAPRO, DSPO, ODMEQ, and the DDRP.

⁴ The executive director of the Office of Force Resiliency is the principal staff adviser to the USD(P&R) and the Secretary of Defense for developing policies, providing oversight, and integrating activities in the areas of sexual assault prevention and response, suicide prevention, diversity management, equal opportunity, drug demand reduction, and other personnel risk-reduction efforts, as well as for DoD collaborative efforts with VA.

appropriate response strategies. As a result, SAPRO was created in October 2005.⁵ SAPRO was designed to serve as DoD's "single point of authority, system accountability, and oversight for the Sexual Assault Prevention and Response (SAPR) program."⁶ It was also to be the single point for DoD interaction with organizations outside of DoD on SAPR issues. Only two areas remained outside SAPRO purview: (1) legal processes are the responsibility of the judge advocates general (JAGs) of the military departments, and (2) evaluations of the performance of military criminal investigations involved in investigating allegations of sexual assaults are the responsibility of the DoD Office of Inspector General.

SAPRO derives its authorities from two main sources. The first is DoDD 6495.01, *Sexual Assault Prevention and Response (SAPR) Program*. It establishes DoD policy and assigns organizational roles and responsibility for prevention, advocacy, and victim care across DoD. The second is DoD Instruction (DoDI) 6495.02, *Sexual Assault Prevention and Response (SAPR) Program Procedures*, which operationalizes the DoD SAPR program.⁷ It provides explicit guidance to commanders on implementing the DoD SAPR policy, including what responsible DoD organizations are expected to do in terms of protocols and procedures, standards, and accountability actions. Together, these two documents provide guidance to the services in developing their own policies, procedures, and processes.

Organizational Structure

As noted, SAPRO was designed to serve as the DoD's "single point of authority, system accountability, and oversight for the Sexual Assault Prevention and Response (SAPR) program."⁸ At the time of our research in 2014–2015, the organizational structure was relatively simple and straightforward, with two principal leadership elements, a single line organization, two major coordinating bodies, and a couple of informal coordinating relationships (see Figure 4.1). SAPRO then reported directly to the USD(P&R)—and through the USD(P&R) to the Secretary of Defense, the White House, and Congress; it now reports to the executive director of the Office of Force Resiliency. SAPRO has the responsibility to ensure that all DoD SAPR organizations implement the DoD SAPR program and strategic plan. The organizations provide data on sexual assault incidents involving military personnel to SAPRO, which compiles this information in progress reports to the DoD leadership, the White House, and Congress. Although SAPRO has overarching responsibility for executing the DoD SAPR program, it does not have authority to direct or force DoD organizations to act. It is DoDD 6495.01 and DoDI 6495.02 that hold DoD organizations accountable for their roles and responsibilities in SAPR. For this reason, a SAPRO official says, it is appropriate to describe his organization's role as "monitoring compliance" of DoD's SAPR programs rather than as an "oversight authority."

This inability to direct or force DoD organizations to act explains why SAPRO has used the IPT, along with a dashboard and website, to ensure that DoD organizations properly execute their assigned SAPR functions. In 2015, the IPT consisted of senior leaders or their

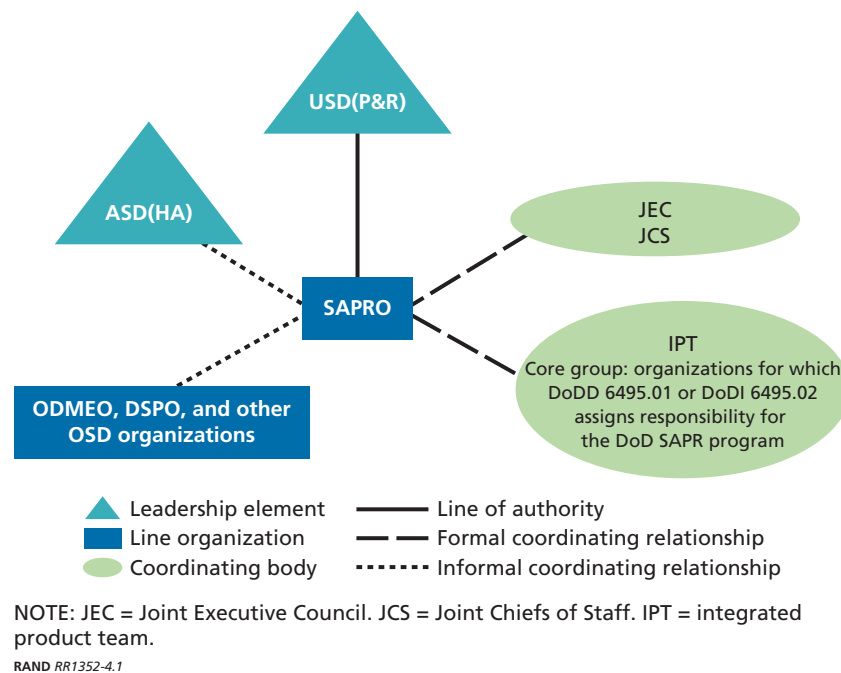
⁵ See SAPRO, *Annual Report on Sexual Harassment and Violence at the Military Service Academies: Academic Program Year 2014–2015*, Washington, D.C., January 2016.

⁶ SAPRO, *Department of Defense Sexual Assault Prevention and Response Program: Response Systems Panel*, briefing slides, June 27, 2013c.

⁷ USD(P&R), *Sexual Assault Prevention and Response (SAPR) Program Procedures*, Washington, D.C., DoDI 6495.02, March 28, 2013b, incorporating change 2 effective July 7, 2015.

⁸ SAPRO, 2013c.

Figure 4.1
Office of the Secretary of Defense Organizations That Address Sexual Assault



representatives from the core group—organizations that DoDD 6495.01 or DoDI 6495.02 identifies as having responsibility for SAPR. They included the Defense Human Resource Activity (DHRA), the ASD(HA), the DoD General Counsel, the secretaries of the military departments, the chief of the National Guard Bureau (NGB), the commander of the JCS, and commanders of combatant commands. A SAPR website and dashboard supplemented the IPT. DoD SAPR organizations were asked to provide proof of compliance by uploading data and reports to a website that SAPRO and other DoD SAPR organizations can access to share information. SAPRO managed the SAPR JEC, which brought together service heads on an ad hoc basis to work on fast-moving issues that are typically beyond the scope of the DoD SAPR strategic plan.⁹ The JEC ensured top-level commitment to SAPR and provided timely direction to subordinate bodies. SAPRO officials characterized interactions with a handful of other OSD organizations and programs, such as ODMEO, ASD(HA), and DSPO, as informal but fairly regular means to exchange information and leverage respective capacity for mutual benefit.

Suicide

Key Office of the Secretary of Defense Organization

Suicide is a major concern for the military community. Between 2001 and 2008, the rate of suicide rose from 10.3 to 16.1 per 100,000 service members.¹⁰ This sharp increase alarmed the DoD leadership, Congress, and the White House. In response, the number of DoD orga-

⁹ DoD, *Department of Defense Sexual Assault Prevention and Response Strategic Plan*, Washington, D.C., January 26, 2015a.

¹⁰ DSPO, *Defense Suicide Prevention Office Annual Report FY 2012*, March 2013.

nizations and programs for suicide prevention and response grew. New ones were created, and a host of existing ones became involved with one another, given that research shows that suicide is tied to an assortment of risk and resiliency factors.¹¹ Further, DoD created several forums to promote learning, information exchange, and collaboration; these include the DoD annual suicide prevention conference, the Suicide Prevention and Risk Reduction Committee (SPARRC), and DCoE.¹²

Despite these efforts (and the considerable human and financial resources these efforts consumed), the suicide rate among military personnel did not decline significantly. This led Congress to ask DoD to form a special task force to come up with better solutions. In August 2009, the DoD Task Force on the Prevention of Suicide by Members of the Armed Forces was created; one year later, it released its conclusions and recommendations for action. Among them was a recommendation for a “Suicide Prevention Policy Division at the Office of the Secretary of Defense within Under Secretary of Defense for Personal Readiness to standardize policies and procedures with respect to resiliency, mental fitness, life skills, and suicide prevention.”¹³

DSPO was formally established in May 2012 under the DASD for Readiness (DASD[R]) to serve as the focal point for suicide prevention policy, training and programs.¹⁴ For the first time, suicide prevention and response would have a single home with a clear mandate for overall DoD policy and oversight. DSPO would “collaborate with the Military Departments to implement the recommendations of the DoD Task Force on the Prevention of Suicide and serve as the DoD lead with the Department of Veterans Affairs and non-governmental organizations on suicide prevention.”¹⁵ Specifically, DSPO would function as the “DoD oversight authority for the strategic development, implementation, centralization, standardization, communication, and evaluation of DoD suicide and risk reduction programs, policies, and surveillance activities to reduce the impact of suicide on Service members and their families.”¹⁶ Further, DSPO’s goals would align with those of its superior offices to promote Total Force Fitness and well-being, the core themes and objectives in DoD’s approach to reducing risk factors and building resiliency in its military population (as well as among its military family members and civilian workforce).

Organizational Structure

Given the complexity of suicide as a problematic behavior and the multitude of entities involved in suicide prevention and response in DoD, this description of DSPO’s organization empha-

¹¹ DSPO, 2013. See also Office of the Surgeon General and National Action Alliance for Suicide Prevention, *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action—A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention*, Washington, D.C.: U.S. Department of Health and Human Services, September 2012.

¹² DoD launched this annual conference in 2002, and it became a joint DoD and VA activity in 2009. See more details in Ramchand et al., 2011.

¹³ U.S. Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, *The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives*, Washington, D.C.: U.S. Department of Defense, 2010.

¹⁴ See Office of Inspector General, U.S. Department of Defense, *Assessment of DoD Suicide Prevention Processes*, Washington, D.C., September 30, 2015.

¹⁵ See Cheryl Pellerin, “Panetta Calls for Leadership on Suicide Prevention,” *DoD News*, June 8, 2012.

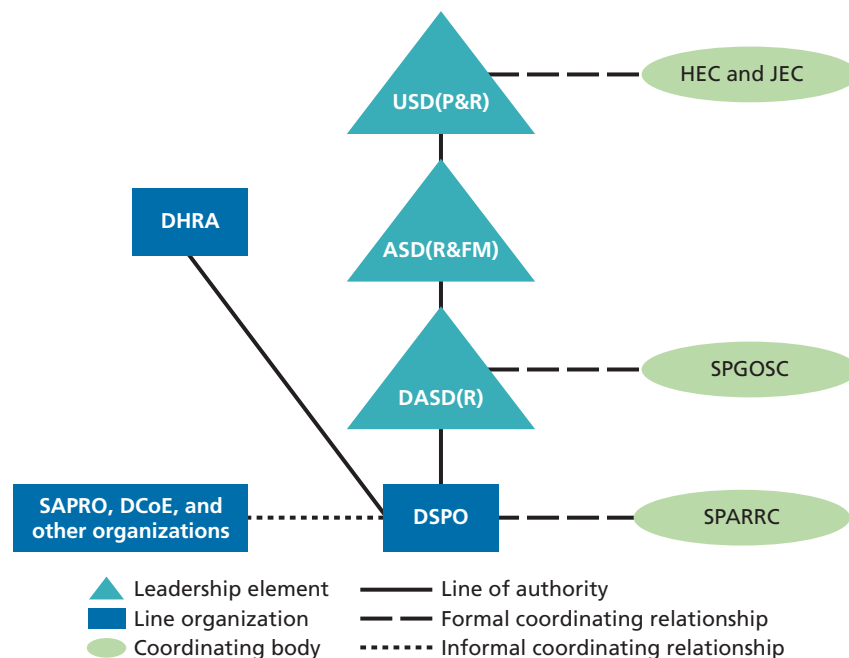
¹⁶ DSPO, 2013, p. 2.

sizes major features in its internal organization and key relationships tied to executing its mission.

The genesis of DSPO and DoD's view of suicide as a behavioral health problem helps explain why DSPO has been simultaneously under the operational control of the USD(P&R) and resourced by DHRA. During the period of our research, DSPO was accountable to both the DASD(R)—its direct superior in the USD(P&R) organizational hierarchy—and to DHRA (see Figure 4.2). Subsequently, reorganization within the Office of the USD(P&R) resulted in the military deputy, who reports directly to the USD(P&R), replacing the DASD(R) as the immediate supervisor for DSPO. This was followed by a further reorganization that placed DSPO under the oversight of the executive director of the Office of Force Resiliency.

In 2015, DSPO was headed by a director and had a small staff team to execute its mission. Four functional divisions defined major work areas: (1) Policy and Plans, (2) Resilience Support, (3) Program Evaluation, and (4) Surveillance. Work was accomplished through nine priority implementation groups. Each group addressed actions called for in the recommendations of the DoD Task Force on the Prevention of Suicide by Members of the Armed Forces and was composed of representatives from key DoD and non-DoD organizations. Group 1, for example, was directed to develop a comprehensive DoD policy on suicide prevention and response, a top recommendation of the task force.¹⁷ The group produced a four-year DoD stra-

Figure 4.2
Office of the Secretary of Defense Suicide Prevention Organizations



NOTE: HEC = Health Executive Council. SPGOSC = Suicide Prevention General Officer Steering Committee.

RAND RR1352-4.2

¹⁷ Importantly, DSPO also drew on two highly regarded studies produced in 2001 to inform its development of the DoD suicide prevention strategic plan. The first is the joint DoD and VA study, "Integrated Mental Health Strategy (IMHS)" (see DoD and VA, *DoD/VA Integrated Mental Health Strategy (IMHS): Strategic Action Summaries*, January 3, 2011). The second is a RAND study, *The War Within: Preventing Suicide in the U.S. Military* (Ramchand et al., 2011).

tegic plan for suicide prevention.¹⁸ Group 2 was tasked to find ways to increase the fidelity of data and improve data processes. The result was the creation of a joint VA/DoD Suicide Data Repository to inform their respective suicide surveillance analysis for policy and program strategy development. Group 3 was tasked to develop a program-evaluation process. The result was an electronic resource management tool to track requirements and funding for suicide prevention programs.

DSPO's central role in these groups was to ensure that their work collectively implemented the DoD strategic plan for suicide prevention and recommendations of the task force. In addition, as the OSD office with sole responsibility for suicide prevention, it frequently developed and maintained tools that serve all of DoD. These included running the Military Crisis Line, producing the annual DoD Suicide Event Report (DoDSER), and compiling quarterly DoD military suicide reports.¹⁹

During the time of our research, DSPO received support and guidance from three governing boards in executing its work. Through these bodies, DSPO pushed new information to top DoD leaders and other DoD and non-DoD organizations active in suicide prevention and response. The first was the SPARRC. Its members were suicide prevention program managers (action officer–level subject-matter experts) for each service branch and representatives. The DSPO director chaired the group in line with DSPO's role as the “focal point for suicide prevention policy and programs.”²⁰ SPARRC met monthly to, among other things, discuss how to effectively develop and coordinate suicide prevention policies and activities across the services, exchange best practices and lessons learned, and reach recommendations for action, which DSPO conveyed to the SPGOSC—the second governing board for DSPO.

The SPGOSC was responsible for overseeing the implementation of the task force's recommendations. Its members were general officers, flag officers, SES, or equivalent-level personnel. The group was cochaired by the DASD(R) and the Principal DASD(HA), reflecting the supervisory lineage of DSPO and the two major bodies with responsibility for suicide prevention in DoD. SPGOSC met quarterly to review, assess, integrate, standardize, and implement DoD suicide prevention policies and programs. DSPO regularly reported to the SPGOSC (directly or through DASD[R]) overall progress in implementing the DoD strategy for suicide prevention, including the work of the priority implementation groups and recommendations from SPARRC.²¹

The third group was the HEC and JEC. The JEC oversaw the development and implementation of IMHS. Its members were mainly senior DoD and VA leaders at the under, assistant, and DASD levels. The HEC was a component of the JEC, with responsibility for implementing the VA/DoD joint mental health strategies. A major part of the HEC's work was removing barriers and challenges to collaboration between DoD and VA. The HEC was cochaired by ASD(HA) and the VA Under Secretary for Health. Its members included the top health officers from the services and deputy assistant–level health program managers from DoD and

¹⁸ DSPO, *Strategic Plan 2012–2016*, 2015a.

¹⁹ RAND/OSD workshop on problematic behavior in August 2014; DSPO, 2013.

²⁰ See DSPO, 2013, p. 10.

²¹ USD(P&R), *Defense Suicide Prevention Program*, Washington, D.C., DoDD 6490.14, June 18, 2013c, incorporating change 1 effective April 1, 2016.

their counterparts in VA. DSPO was periodically called to report progress in implementing activities related to the joint VA/DoD IMHS and Suicide Data Repository.²²

DSPO also had informal coordinating relationships with other OSD organizations. These organizations were not members of SPARRC or other forums active in implementing the DoD suicide prevention strategic plan but were organizations with which DSPO exchanged information and collaborated on an ad hoc basis.²³

Substance Abuse

Key Office of the Secretary of Defense Organizations

Misuse of drugs and alcohol is unfortunately no less challenging within the active-duty military than within the U.S. population at large. The IOM reported survey data showing that active-duty personnel are less likely than their civilian counterparts to use illegal drugs but more likely than civilians to illegally use prescription drugs and engage in heavy alcohol use.²⁴ To address this problem, DoD has a range of education, prevention, diagnosis, treatment, and disposition activities related to the use of illegal and legal substances. However, recent events and new information have caused DoD to reorganize and reprioritize its efforts addressing substance use:

- a perception of increased substance abuse linked to multiple, extended deployments since 2001
- the number of personnel being prescribed potentially addictive painkillers because of injuries
- a 2012 IOM report recommending that DoD acknowledge the level of substance misuse, improve screening, and increase access to care.²⁵

These factors contributed to the Office of the Chief Medical Officer updating DoD's comprehensive plan for substance misuse²⁶ and the creation of the DHA in 2013. The 21 actions in the plan reflected the recognition within DoD's leadership that substance misuse in the military is a reality that cannot be eliminated and thus must be managed continuously. They also revealed awareness that managing substance use is complicated by the fact that some substances are illegal (e.g., cocaine), some are illegal when used outside of prescribed treatment (e.g., painkillers), some are generally legal but linked with illegal behavior (e.g., alcohol or drunk driving), and some are legal but negatively affect readiness (e.g., smoking). Organizationally, this has meant that three DoD communities have been involved in addressing the negative effects of substance use: the medical community (the DHA), the personnel management and human resource (HR) community, and the drug-testing community (the DDRP).

²² See DHA, "DoD/VA Program Coordination Office (DVPCO)," undated.

²³ For example, see details of DSPO's informal relationship with SAPRO in the next section on effectiveness of OSD organizations in managing problematic behavior.

²⁴ IOM, 2013.

²⁵ IOM, 2013.

²⁶ Office of the Chief Medical Officer, TRICARE Management Activity, DoD, *Section 596(b)(8) of the FY 2010 National Defense Authorization Act (NDAA): Update to the Comprehensive Plan on Prevention, Diagnosis, and Treatment of Substance Use Disorders (SUDs) and Disposition of Substance Use Offenders in the Armed Forces*, July 2013.

Further, these communities have had somewhat overlapping LOEs, and they have interacted differently with each other depending on the particular substance-use issues. For example, a service member testing positive for an illegal drug under the DDRP has been referred to the medical community for treatment and considered for disciplinary action by the personnel management community. Then again, a 19-year-old service member caught with alcohol might interact only with the personnel management community.

Organizational Structure

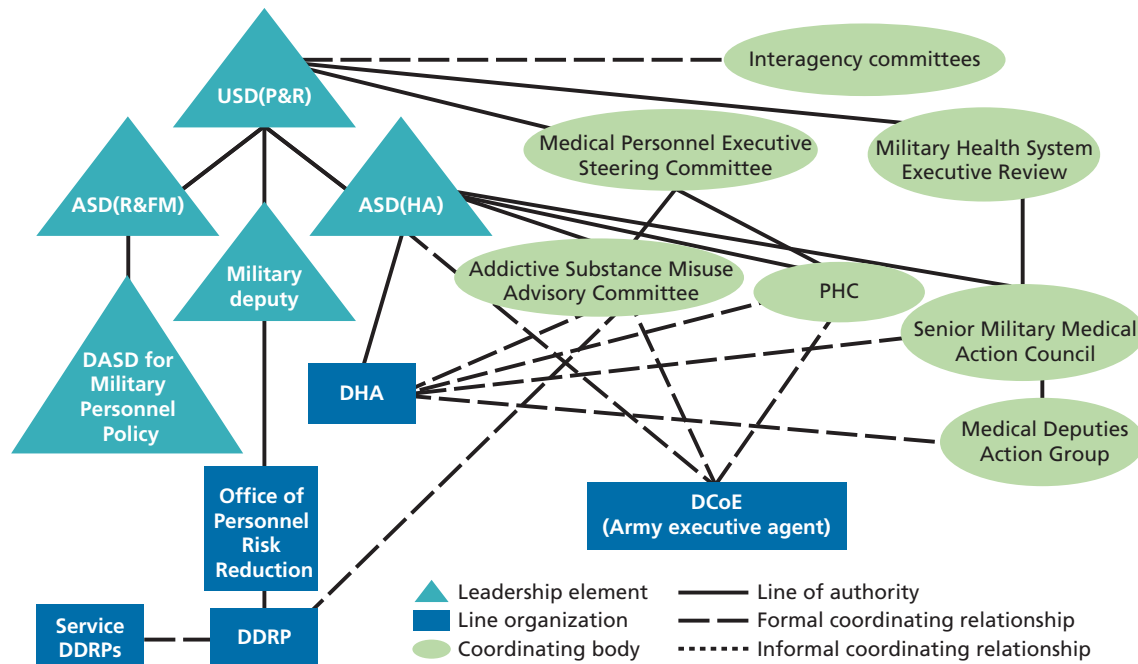
As discussed above, DoD divides the responsibilities for handling problematic substance use among three relatively separate communities: medical, personnel management functions, and drug testing. In OSD, this is shown by the fact that substance-use policy across the spectrum from education to disposition meets only at the level of the Office of the USD(P&R). Figure 4.3 shows the complex organizational relationships that existed in 2015 among OSD organizations to address substance use.

At the time of our research, responsibilities of the Office of the USD(P&R) were as follows:

- ASD(HA) for medical
- ASD(R&FM) for personnel management²⁷

Figure 4.3

Office of the Secretary of Defense Organizations Addressing Substance-Use Organizations



NOTE: PHC = Psychological Health Council.

RAND RR1352-4.3

²⁷ With the elimination of the position of the ASD(R&FM) at the end of 2015, the Assistant Secretary of Defense for Manpower and Reserve Affairs (ASD[M&RA]) became responsible for personnel management.

- military deputy to the USD(P&R) for drug testing under the DDRP.²⁸

Within the medical realm, the ASD(HA) is responsible mainly for diagnosis and treatment, plus some prevention of substance misuse. The position has oversight over the DHA, which was established as an OSD-managed defense agency in 2013 and now houses much of DoD's health care service delivery work. At the time of our research, DCoE was managed by the Surgeon General of the Army acting as the executive agent²⁹ (delegated from the Secretary of the Army) for a DoD-wide activity—although it was placed under DHA authority in 2016. In 2015, ASD(HA) also oversaw all the medical community's substance-use work through three forums used to raise and discuss DoD-wide issues: the Addictive Substance Misuse Advisory Committee,³⁰ the PHC,³¹ and the Senior Military Medical Action Council. Substance-use policy issues that could not be resolved were elevated to the USD(P&R) in the Medical Personnel Executive Steering Committee and Military Health System Executive Review.

Most of the personnel management responsibility—often referred to as line management—ultimately resides with the military departments and services, with OSD oversight provided by ASD(R&FM) (now the ASD[M&RA]). This includes policies for handling personnel who report or are diagnosed with substance-use problems, test positive for illegal drug use, or are caught possessing illegal substances.

Carried out through the DDRP, the drug-testing portion of the substance-use effort was managed by the military deputy to the USD(P&R) (now the executive director of the Office of Force Resiliency) within the Office of Personnel Risk Reduction. The results of drug testing feed into both the medical and personnel management communities.

Sexual Harassment and Unlawful Discrimination

Key Office of the Secretary of Defense Organization

Unlawful discrimination and sexual harassment are problematic behaviors that have received longstanding attention from DoD. In response to the racial disparities within the ranks of the military and resulting tensions and harassment of the Vietnam era, DoD resolved to improve the fairness of its personnel practices and to work toward achieving EO for all service members. As a foundation for these efforts, it looked to civilian equal employment opportunity (EEO) laws that banned discrimination and harassment against someone seeking to pursue a career or position.³² In 1963, the Secretary of Defense issued the department's first EO policy, DoDD 5120.36, "Equal Opportunity in the Armed Forces." This established not only a policy to "conduct all activities free from racial discrimination and to provide equal opportunity for

²⁸ At the end of 2015, the DDRP and its parent organization, the Office of Personnel Risk Reduction, were placed under the purview of the executive director of the Office of Force Resiliency.

²⁹ USD(P&R), *Executive Agent (EA) for the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE)*, DoDD 6000.17E, January 2, 2013a, canceled April 25, 2016.

³⁰ USD(P&R), *Problematic Substance Use by DoD Personnel*, Washington, D.C., DoDI 1010.04, February 20, 2014; USD(P&R), "Charter: Addictive Substance Misuse Advisory Committee," December 24, 2013d.

³¹ USD(P&R), *DoD Directors of Psychological Health*, Washington, D.C., DoDI 6490.09, February 27, 2012b, incorporating change 1 effective October 2, 2013; ASD(HA), "Official Designation," March 5, 2013 (creating the PHC).

³² Military Leadership Diversity Commission, 2011, p. 12.

all uniformed members” but also the position of DASD for Civil Rights.³³ This was followed, in 1969, by the issuance of the first Human Goals Charter, which called for the department to do the following:

- Provide service members with “the opportunity to rise to as high a level of responsibility as possible based only on individual talent and diligence”
- Ensure that “equal opportunity programs are an integral part of readiness and to make the military a model of equal opportunity for all, regardless of race, color, sex, religion, or national origin.”³⁴

Although DASD for Civil Rights is a position that no longer exists, the policy outlined in DoDD 5120.36 laid the foundation for the current DoD MEO program, with policies outlined in DoDD 1350.2. The DoD MEO program is the entity responsible for EO policy, with DoDD 1020.02E, *Diversity Management and Equal Opportunity in the DoD*, mandating that the director of ODMEEO oversee the DoD MEO program.

We discuss organizational approaches to combating sexual harassment and discrimination together because both are components of EO efforts at the OSD level³⁵ and because the management and organizational framework supporting these two behaviors is intertwined and dealt with in ODMEEO.

Organizational Structure

Currently, ODMEEO has oversight of addressing sexual harassment and discrimination in the department. ODMEEO oversees a variety of programs, including the MEO program that applies to military service members, the EEO program that applies to DoD civilian employees, and the Diversity and Inclusion (D&I) program that applies to both military service members and DoD civilians. Military anti-sexual harassment and antidiscrimination efforts fall within the MEO program in ODMEEO.

In 2003, the Deputy Assistant Secretary of Defense for EO was elevated to the Deputy Under Secretary of Defense for EO, and the position was filled by a political appointee. When that political appointee left in 2006, the Office of the Deputy Under Secretary of Defense for EO was renamed ODMEEO and aligned under the Deputy Under Secretary of Defense for Plans.³⁶ Although ODMEEO is a relatively newly established office, MEO efforts within the department have existed for some time.

During the period of our research in 2014–2015, as shown in Figure 4.4, ODMEEO reported to the military deputy to the USD(P&R). Recently, however, it was placed under the authority of the newly established executive director of the Office of Force Resiliency.

³³ Defense Equal Opportunity Council, *Report of Task Force on Discrimination and Sexual Harassment*, Vol. II: *Additional Materials*, May 1995b, Tab C, p. 5.

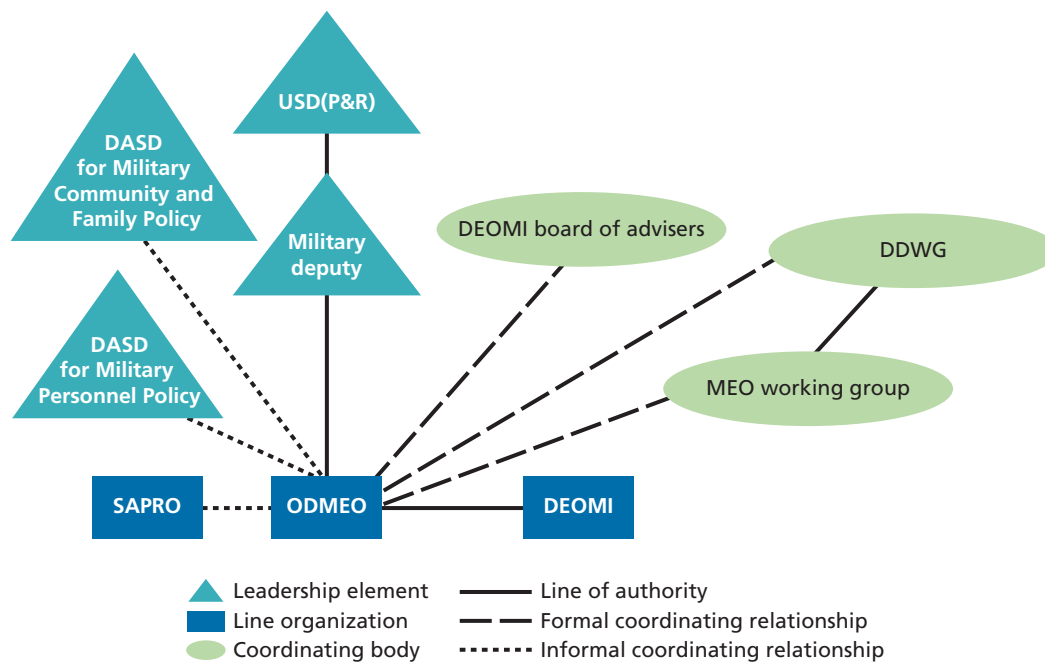
³⁴ U.S. General Accounting Office, *Military Equal Opportunity: Certain Trends in Racial and Gender Data May Warrant Further Analysis*, Washington, D.C., NSIAD-96-17, November 17, 1995, p. 2.

³⁵ DoDD 1350.2 defines EO as follows:

The right of all persons to participate in, and benefit from, programs and activities for which they are qualified. These programs and activities shall be free from social, personal, or institutional barriers that prevent people from rising to the highest level of responsibility possible. Persons shall be evaluated on individual merit, fitness, and capability, regardless of race, color, sex, national origin, or religion.

³⁶ Military Leadership Diversity Commission, 2011, pp. 95–96.

Figure 4.4
Office of the Secretary of Defense Organizations Addressing Sexual Harassment and Discrimination



RAND RR1352-4.4

ODMEO is led by an SES-level director, who chairs two working groups that serve as advisory bodies to make recommendations to the USD(P&R) about ODMEO's efforts: the Defense Diversity Working Group (DDWG) and the Defense Equal Opportunity Management Institute (DEOMI) board of advisers. Both these working groups are made up of members at the SES or flag- or general-officer level who are responsible for D&I in their organizations.³⁷ ODMEO also leads working groups for each of its key programmatic areas, including MEO. Informal working relationships exist between ODMEO and other OSD offices, including the DASD for Military Personnel Policy, SAPRO, the DASD for Military Community and Family Policy, and potentially other offices focused on areas of problematic behavior.

Hazing

Key Office of the Secretary of Defense Organization

Hazing is not a new problematic behavior in the military, but it is one that has recently received heightened attention within DoD in the wake of several recent tragic incidents. These alleged hazing incidents resulted in the high-profile deaths of service members, renewing interest from the public and Congress in eliminating dangerous hazing rituals within the department. Unlike the other behaviors examined in this report, antihazing efforts have not been incorporated into a stand-alone, established program. With hazing being a current hot issue in the

³⁷ The DEOMI board of advisers serves in an advisory role on issues specifically related to DEOMI. DEOMI, overseen by ODMEO and located on Patrick Air Force Base, is responsible for developing and delivering human relations training, which encompasses all training related to MEO.

department, DoD has taken steps—though largely ad hoc ones—to reduce the incidence of this behavior within its ranks.

As part of these recent steps, DoD issued a revised policy memo in December 2015 that updates the department's definition of hazing to a more precise version (see Chapter One). The purpose of this updated definition is to narrow the focus specifically to hazing behaviors, which has an inclusionary aim, and to distinguish hazing from other types of negative behaviors, such as bullying, which has an exclusionary aim.

Tragic incidents connected with hazing behavior resulted in congressional attention and legislation requiring a report on hazing in the armed forces to the congressional defense committees in 2013.³⁸ ODMEIO was tasked as the OSD lead to respond to this request because combating hazing was seen as related to ODMEIO's broader D&I mission. In this role, ODMEIO will take the lead on establishing antihazing policy and develop a strategic way forward to combat hazing in the department.

Organizational Structure

As just noted, tragic incidents connected with hazing behavior resulted in congressional attention and legislation requiring a report on hazing in the armed forces to the congressional defense committees in 2013. ODMEIO was tasked as the OSD lead to respond to this request because combating hazing was seen as related to ODMEIO's broader D&I mission. The office's senior military adviser currently manages antihazing efforts within ODMEIO. Like with sexual harassment and discrimination, the DDWG is the advisory body for hazing issues that need to be brought to the attention of senior leaders. ODMEIO's senior military adviser leads a hazing working group that engages with the services on hazing issues. Figure 4.5 shows the organizational structure at the time of our research. As noted earlier, the authority for ODMEIO was shifted from the military deputy to the executive director of the Office of Force Resiliency at the end of 2015.

What Coordination and Oversight Mechanisms Are Currently Being Used?

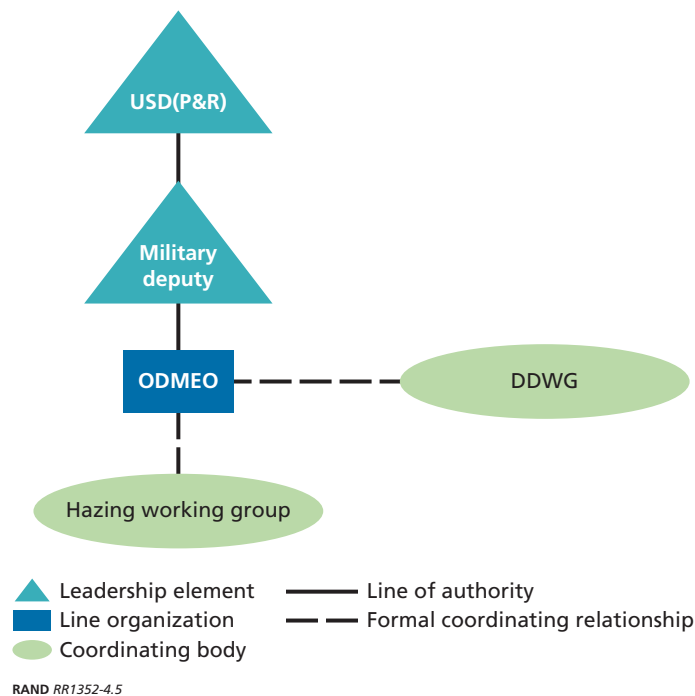
In looking across the organizational charts in the previous section, we assessed the coordination and oversight mechanisms that OSD organizations used in 2014–2015 that deal with the problematic behaviors under examination. We summarize that assessment here.

Coordination Mechanisms

Coordination mechanisms were generally formal and often limited to a single problematic behavior; collaboration across problematic behaviors was usually informal, infrequent, and ad hoc (see Table 4.1). Except for the hazing working group, all organizations to address problematic behavior had OSD, other DoD, and, in some cases, non-DoD coordination partners and mechanisms that were used every few months or on an as-needed basis. Much of the coordination between organizations dealing with different problematic behaviors occurred in the form of informal interactions among staff members seeking specific types of assistance. For example, SAPRO and DSPO cofunded a study to better understand the connections between sexual assault and suicide, and SAPRO and ODMEIO jointly observed SAPR training at the service

³⁸ Pub. L. 112-239, 2013.

Figure 4.5
Office of the Secretary of Defense Antihazing Organization



academies. The ad hoc nature of these collaborative activities is not necessarily bad and has resulted in useful outcomes in terms of reporting and data-sharing. Moreover, regular, formal interactions can be inflexible and inefficient. That said, discussants indicated that they have little opportunity to engage in innovative forms of collaboration or develop new relationships outside their problem areas while still satisfying their current requirements.

Oversight Mechanisms

Oversight policies and plans were well delineated in some cases; numerous and confusing in other cases; and mostly lacking in one case (Table 4.2). Both SAPRO and DSPO have clearly focused directives and well-developed strategic plans that address SAPR and suicide prevention programs, respectively. There is a large amount of substance-use documentation; however, much of it is focused on drug testing and enforcement and less of it on prevention and treatment. ODMEO has a directive that encompasses diversity, EO, and inclusion. Although it is developing an updated DoDI for MEO, it lacks a strategic plan for antidiscrimination and anti-sexual harassment programs. Because DoD has only recently turned its attention to hazing, no current formal issuances govern DoD's response to this problematic behavior. However, the recent Deputy Secretary of Defense memorandum on hazing requires each DoD component to track hazing allegations and submit an annual report to ODMEO in the future. Additionally, as mentioned, working groups at the OSD and service levels have been stood up to respond to congressional inquiries on this topic.

The various OSD oversight mechanisms dealing with sexual assault, substance misuse, and suicide prevention appear to be exercised on a regular basis. At the time of our research, MEO and the hazing working group had each produced one congressionally mandated report,

Table 4.1
Summary of Office of the Secretary of Defense's Efforts to Coordinate Addressing Problematic Behavior

| Problematic Behavior | Main OSD Office | Coordination Partner | Coordination Mechanism | Frequency of Use | Result |
|--------------------------------------|-----------------|--|--------------------------------|------------------------------------|--|
| Sexual assault | SAPRO | DSPO, ODMEO | Informal | As needed or as opportunity arises | Study |
| | | ASD(HA) | Informal | | Survey |
| | | JCS | JEC | | Data-sharing report |
| Substance abuse | None | Interagency Surgeon general Psychiatric health directors Service providers DSPO | Committee meetings | Quarterly or semiannually | Reports Briefings Standards |
| Suicide | DSPO | Assistant to the Secretary of Defense for Public Affairs, ASDs, DASDs, DHA SAPRO DCoE National Action Alliance for Suicide Prevention | Committee meetings Informal | Quarterly or as needed | Strategic communications Training coordination |
| | | VA | Committee meetings | | |
| Sexual harassment and discrimination | ODMEO | Military Personnel Policy | Informal | As needed | Congressional response Data-sharing |
| | | SAPRO | Informal, victims | As needed, quarterly | |
| | | Military Community and Family Policy | Council meetings | As needed | |
| | | Other problematic behavior | Informal | As needed | |
| Hazing | ODMEO | No OSD-level coordinating partners | Not applicable | Not applicable | Not applicable |

but there is currently no requirement to continue this kind of reporting beyond recently mandated component-level annual reporting to ODMEO. Metrics that OSD organizations addressing problematic behavior have developed to evaluate the success of program efforts appear to be primarily output-focused as opposed to outcome-focused. Frequently, many entities are involved in addressing problematic behavior, including commanders to counselors, trainers, and JAG officials. For this reason, a major emphasis in the work of these OSD organizations with their oversight responsibility has been to create a unified or integrated picture of the status of problems and progress in implementing plans and actions. Consequently, it is not surprising that most metrics—both formal and tacit—that these OSD organizations use tend to focus on progress in implementing a strategic plan or in creating a single DoD data repository.

SAPRO, for example, collects data on the number of reported sexual assault incidents annually in the Defense Sexual Assault Incident Database and tracks completion of actions by each responsible organization in the strategic plan. Other programs to address problematic behavior that we examined in this study similarly work to create a single unified data system or a unified annual incident report for all of DoD. These basic output metrics are essential to inform oversight and coordination between service and OSD offices and decisionmaking by

Table 4.2
Summary of Office of the Secretary of Defense's Efforts for Oversight of Problematic Behavior

| Problematic Behavior | Oversight Policy or Plan | Oversight Mechanism | Frequency of Use | Metric |
|--------------------------------------|---|---------------------|----------------------------|--|
| Sexual assault | DoDD Strategic plan | IPTs | Bimonthly | Output Outcome |
| | | Database | Quarterly and annually | |
| | | Standards | Continuously | |
| | | Report | Annually | |
| Substance abuse | Multiple DoDDs, DoDIs, policies, charters, and statements | Steering committee | Semiannually | Outcome Output (only for testing) |
| | | Councils | Quarterly and semiannually | |
| | | Action group | Quarterly | |
| | | Testing | Annually | |
| Suicide | DoDD Strategic plan | Surveillance tool | Continuously | Outcome Output (metrics being developed) |
| | | Mapping | Periodically | |
| | | Committee | Monthly, as needed | |
| Sexual harassment and discrimination | DoDD No strategic plan | Working groups | Quarterly | Output Outcome |
| | | Board of advisers | Quarterly | |
| | | Report | One so far | |
| Hazing | No authorities or policies | Working groups | Quarterly | Output Outcome |
| | | Report | One so far | |

NOTE: An output is a measure of performance (task completion). An outcome is a measure of effectiveness (progress with respect to a planning objective).

the DoD leadership. They are also critical for DoD to report to, and seek resources and guidance from, the legislative and executive branches.

As for outcome metrics, our research indicates that they emphasize generally a reduction in incidents, an increase in reporting, or an improvement in culture or environment. Again, SAPRO provides a useful example. Although the total elimination of sexual assault is desired, it is not seen as a realistic goal. Instead, SAPRO makes closing the gap between prevalence estimates and formal reports to authorities a key outcome metric to gauge the culture, environment, and trust in the system.

How Well Are Office of the Secretary of Defense Organizations Managing Problematic Behavior?

Evaluation Approach Taken to Assess Managerial Practices

Ideally, the RAND study team would like to have evaluated OSD management of problematic-behavior programs based on a quantitative comparison of different organizational features, policies, and practices on the one hand and behavioral outcomes on the other hand. Unfortu-

nately, this is not a practical research design at present. In most cases, either outcome measures for problematic behavior do not exist or the relationship between them and OSD management is unclear. Additionally, it is difficult to establish an appropriate baseline or control with which to compare organizations and outcomes. Consequently, we have chosen to qualitatively assess OSD problematic-behavior organizations based on certain managerial standards derived from the organizational design literature:³⁹

- unity of command: Authority and responsibility are concentrated organizationally.
- mission focus: Responsible organizations focus their efforts on problematic behavior.
- span of control: Organizational functions (e.g., diagnosis, treatment, response, enforcement) are integrated.
- organizational collaboration: Organizations that share common risk or protective factors or prevention methods collaborate.
- planning and assessment: Organizations have explicit objectives, plans, tasks, and milestones; implementation roles and responsibilities; and measures of performance and effectiveness.
- resources: Organizations have sufficient personnel and funding to accomplish their missions.

We recognize that these managerial standards are not absolute. There might be good reasons for a particular organization not to fully apply one or more of them based on the nature of the problematic behavior being addressed or the political or bureaucratic environment in which it is operating. Furthermore, an organization's reliance on one standard (e.g., organizational collaboration) can compensate for shortcomings with respect to other standards (e.g., unity or command or span of control). Finally, the fact that some of our selected behaviors do not have central offices devoted to them (as shown above) makes it difficult to know whether we have fully analyzed every OSD organization with a stake in reducing incidence of the behavior. Nevertheless, the foregoing set of standards provides a useful, albeit rough, method for evaluating key structural and procedural dimensions of organizations addressing problematic behavior.

Evaluation of Office of the Secretary of Defense Management

Although our study was not designed to determine the overall effectiveness of OSD organizations in addressing problematic behavior, *our research so far indicates that OSD's management conforms to organizational design principles more in some cases than in others.* In the remainder of this section, we provide a high-level summary of managerial practices in each problematic area, followed by a discussion of the key factors that influence these practices. At the end of the section, Table 4.3 summarizes the evaluation results across the problematic behaviors in terms of the six evaluation criteria discussed above.

³⁹ This literature has a long social science and business management pedigree going back to Max Weber's studies on bureaucratic organizations and Frederick Taylor's principles of scientific management. Well-known works on structuring and managing effective organizations on which this study has relied include Jay R. Galbraith, *Organization Design*, Reading, Mass.: Addison Wesley Publishing Company, 1977; Paul R. Lawrence and Jay W. Lorsch, *Organization and the Environment: Managing Differentiation and Integration*, Boston, Mass.: Harvard Business School Press, 1986; Daniel Robey and Carol A. Sales, *Designing Organizations*, Burr Ridge, Ill.: Irwin, 1994; and Michael Allison and Jude Kaye, *Strategic Planning for Nonprofit Organizations: A Practical Guide and Workbook*, Hoboken, N.J.: Wiley, 2005.

Sexual Assault

In the area of sexual assault, the key organization is SAPRO, which overall performs quite well on these measures.

Unity of Command

Unity of command is most importantly enabled by SAPRO's role as the single point of authority for SAPR within DoD. Departmental guidance clearly defines roles and responsibilities for SAPRO and other DoD organizations in the SAPR program.

Mission Focus

SAPRO has a clear, undiluted mission focus. Although linkages between sexual assault and other problematic behaviors are acknowledged and knowledge of these linkages informs SAPR policy, SAPRO and the DoD SAPR program focus solely on enabling the capacity to prevent and respond to sexual assault. SAPR training for leaders and service members aims to produce a climate and culture that do not tolerate sexual assault. SAPR personnel and procedures help victims to obtain medical attention, justice, and transfers to jobs and locations away from their alleged attackers.

Span of Control

In terms of span of control, organizational functions for SAPRO and other DoD organizations with roles and responsibility for SAPR are well integrated. The DoD SAPR program is executed through five related LOEs outlined in the strategic plan. Tasks supporting each LOE are aligned for collective coherence, and appropriate DoD organizations are designated as offices of primary responsibility (OPRs). SAPRO has a central role in developing the plan and assigning tasks, roles, and responsibilities in consultation with senior DoD leaders.

Organizational Collaboration

As for organizational collaboration, SAPRO works closely with other organizations inside and outside DoD to implement the DoD SAPR strategic plan. However, collaboration with organizations that do not have explicit roles and responsibilities in the strategic plan has not been extensive, for practical reasons. Congress and DoD leaders have also given SAPRO a large number of tasks to complete. Consequently, SAPRO has scarce time, personnel, or resources to collaborate with organizations that have limited SAPR responsibilities. Nonetheless, SAPRO has collaborated to the extent possible with several other OSD offices. The joint study with DSPO is an instance of collaboration made possible by a mutual interest in exploring the connections between suicide and sexual assault. This connection was built on a professional relationship between DSPO and SAPRO officials that preceded this collaborative effort and was made possible by the availability of funds from both organizations. Since 2012, SAPRO has been funding and providing subject-matter expertise to DEOMI to ensure that course materials taught in EO courses reflect current policy and guidance. SAPRO also provides a subject-matter expert to instruct at each of DEOMI's Leadership Team Awareness Seminars. SAPRO also has an ongoing collaborative effort with DEOMI to develop and track SAPR questions on the DEOCS. SAPRO has also been providing DEOMI with subject-matter expertise for its Assessment to Solutions web portal that assists units with resolving climate issues identified in the survey. SAPRO also regularly collaborates with the DoD Family Advocacy Program on a range of initiatives, including providing subject-matter expertise to its Family Advocacy Command Assistance Team trainings and partnering to support military participation in CDC's

National Intimate Partner and Sexual Violence Survey (administered to military samples in 2010 and 2016). Finally, in August 2015, SAPRO launched the Prevention Collaboration Forum, wherein it has been working with ODMEO, DSPO, the Family Advocacy Program, Personnel Risk Reduction, and Operation Live Well to explore common risk and protective factors addressed in programs that these OSD offices manage. Force Resiliency is now the proponent of this forum.

Planning and Assessment

SAPRO and the DoD SAPR program exemplify many best practices in planning and assessment. Policy, authority, roles, and responsibilities are clearly stated and well aligned in DoD guidance. A strategic plan builds on this DoD guidance by assigning tasks and defining timelines and metrics for completion. This ensures comprehensive implementation of and accountability for the DoD SAPR program. Organizations work individually to execute their SAPR responsibilities but not without considering actions of other organizations and the whole DoD effort. For example, the DoD SAPR strategic plan designates several organizations as having primary responsibility for certain LOE tasks. Although each OPR is free to choose an approach that is right for it, each must support the same overall objective.

Resources

The level and timeliness of resources has affected OSD's ability to manage SAPR programs. For example, SAPRO does not always have the personnel needed to conduct field visits to verify the information reported to it. A SAPRO internal manpower study calls for two new general-schedule civilian positions in the near term for its assessment team and to assist work in other areas. SAPRO says that it would like to see five to ten additional general-schedule positions so it can execute, in a timely manner, responsibilities associated with the 33 provisions assigned to it in the NDAA for fiscal year (FY) 2014 to inform policy and programming decisions.

Besides these manpower issues, timeliness of funding is also critical. SAPRO personnel report that legislative delays in federal budget approval in recent years, combined with restrictions on how funds are executed, have caused considerable stress. First, when needed funds are absent, contracts and work are delayed or canceled. Second, when funds become available, there might be a rush to spend them within the remaining time, and rushed spending does not always yield the best results. Third, delayed receipt of funds can impede their execution or block it entirely. Rules on spending can impose a timeline or benchmarks to which SAPRO can no longer adhere. A contract offer can also have a sell-by date. All these issues can impair planning and funding requests in subsequent years.

SAPRO credits four factors with influencing its managerial practices and substantively bolstering its ability to advance the DoD mission in SAPR:

- Former Secretary of Defense Chuck Hagel's commitment to meetings every two months (formerly weekly) with the SAPRO director and leaders of military departments and services from 2013 to 2015 encouraged all DoD organizations to work harder to address the sexual assault problem during a time of intense scrutiny.⁴⁰ Direct Secretary of Defense

⁴⁰ The November 2014 *DoD Report to the President of the United States on Sexual Assault Prevention and Response* (DoD, Department of Defense Report to the President of the United States on Sexual Assault Prevention and Response, Washington, D.C., November 21, 2014) acknowledges the deep interest and involvement of the Secretary of Defense as a catalyst to SAPR program improvement. For example, the Secretary of Defense recently directed SAPRO to host a senior summit each

support of the SAPR program after 2015 has focused on providing guidance on complex issues requiring significant cross-service coordination, such as the DoD Retaliation Prevention and Response Strategy published in May 2016.

- The installation of a two-star general officer as the director of SAPRO underscored SAPR's importance in the hierarchy of DoD issues and might have influenced the services, too, to appoint senior military leaders to head their SAPR programs.
- The SAPRO director's direct communication with, and access to, the USD(P&R) familiarizes the USD(P&R) with SAPR issues and priorities and makes it easier for SAPRO to make its case for assistance and cooperation from the USD(P&R).
- SAPRO's internal subject-matter expertise and experience in navigating DoD's bureaucracy and politics ensured that the LOEs, tasks, and OPRs in the DoD SAPR strategic plan were appropriately defined, designated, and aligned.

It is important to note that these factors did not materialize overnight. A succession of SAPRO directors shared the same vision and worked in concert to build on the work of their predecessors. A SAPRO official with whom we spoke also credited success in staff recruiting and retention for knowledgeable, committed, stable, and trusted personnel to make SAPRO effective internally as a team, as well as in its interactions with other organizations.⁴¹

Suicide Prevention

Although DSPO shares some of the qualities of SAPRO, OSD's suicide prevention efforts do not conform to managerial best practices to the same extent as its sexual assault prevention efforts.

Unity of Command

DoDD 6490.14 provided the basis for unity of command within the suicide prevention realm by establishing DSPO as a major oversight authority for the strategic development, implementation, standardization, communication, and evaluation of prevention and resilience programs, policies, and surveillance areas across DoD. However, there are practical limits to what DSPO can do to exercise oversight authority. Suicide prevention is a complex issue, and many organizations are involved. Each organization has its own chain of command, goals, activities, and resources. Although each has roles and responsibilities in implementing the Defense Suicide Prevention Program, none is explicitly required to report its work or effectiveness to DSPO.⁴²

Mission Focus

DSPO's sole mission focus is to reduce suicides across DoD through a multipronged strategy. DoDD 6490.14 establishes the roles and responsibilities of DSPO and other DOD organizations in achieving this mission.

academic program year for service academy leaders and to incorporate them into the SAPR executive IPT to facilitate collaboration and exchange of best practices. This order followed release of the latest *Annual Report on Sexual Harassment and Violence at the Military Service Academies* (SAPRO, *Annual Report on Sexual Harassment and Violence at the Military Service Academies*, Washington, D.C., February 2015), which shows that the estimated number of instances of sexual assault and harassment at these institutions greatly outnumber reports made to authorities. This annual report assesses prevention, investigation, accountability, and victim advocacy and assistance at the military service academies. See the 2014–2015 edition at SAPRO, 2016.

⁴¹ Author discussion with SAPRO officials, September 17, 2014.

⁴² For more information about the Defense Suicide Prevention Program, see DoDD 6490.14.

Span of Control

In terms of span of control, although DSPO supports oversight over the services and DoD suicide prevention and resiliency programs, other OSD organizations are responsible for other suicide-related functions. For example, the Assistant to the Secretary of Defense for Public Affairs oversees messaging on suicide prevention–related issues in collaboration with DSPO; ASD(HA) owns health care–related aspects of suicide prevention and collaborates with DSPO on treatment policies; and the executive director of the Office of Force Resiliency establishes suicide prevention policy. Thus, the control over suicide prevention issues is divided functionally and hierarchically.⁴³

Organizational Collaboration

OSD suicide prevention organizations collaborate through a variety of formal and informal mechanisms—most importantly, through cross-organizational working groups. These include committees and summits for sharing data, lessons learned, and best practices. These groups allow DSPO to have a direct line of communication and interaction with various entities involved in suicide prevention. They also facilitate information exchange, feedback, cooperation, and coordination when many organizations and varied expertise inside and outside DoD have roles and responsibilities in suicide prevention.

Planning and Assessment

Turning to planning and assessment, we see that DSPO has a strategic plan with five goals, 35 objectives, associated action items, and output measures. They are intended to act on the recommendations from the DoD Task Force on the Prevention of Suicide by Members of the Armed Forces and other guidance, such as *2012 National Strategy for Suicide Prevention*.⁴⁴ DSPO has also expended considerable energy in collecting 20-plus distinct data sets to determine risk and resiliency factors and trends to better inform suicide prevention activities and initiated a mapping exercise to explore how organizations can more strategically align their efforts. However, there are notable shortcomings. The DoD inspector general determined in the fall of 2015 that the plan was not “a working document that was monitored and updated annually” and that a training plan for suicide prevention—drafted in 2013—was never published.⁴⁵ Also, outcome-oriented measures of effectiveness are lacking in the plan, despite a series of meetings and summits. Moreover, explicit resource requirements and timelines for completing objectives are missing.

Resources

Significant resources are necessary for DSPO to fully execute its four major functions in (1) policy and plans, (2) resilience support, (3) program evaluation, and (4) surveillance. However, DSPO is a relatively lean organization. Its base budget is between \$7 million and \$8 million annually, with additional funding from congressional action of about \$20 million

⁴³ The establishment of an executive director of the Office of Force Resiliency under the USD(P&R) since the fall of 2015 to oversee diversity management and EEO, suicide prevention, and the Office of Personnel Risk Reduction provides a more direct reporting chain for these offices to the USD(P&R). Because the reporting chain is still fairly new and was introduced after we completed our research and analysis in the summer of 2015, the full impact of this change on defense suicide policy integration and strategic plan implementation has yet to be examined.

⁴⁴ Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012.

⁴⁵ See Office of Inspector General, 2015, p. 16.

for operations and maintenance. According to senior program staff, this amount of funding should remain steady or increase in the next few years, given the government's emphasis on suicide prevention.⁴⁶ A large portion of the funding goes toward oversight, maintenance, and operation of the Vets4Warriors call center that provides 24-hour-per day, seven-day-per-week, DoD-wide peer support. The office could not execute its entire budget in FY 2013, partly because of late funding and partly because of the time needed to procure additional project-related services to support the small number of full-time staff members.

Substance Abuse

In general, OSD activities dealing with substance abuse have not conformed to the managerial standards outlined above.

Unity of Command

At the time we conducted our research, several lines of authority in the realm of substance abuse flowed through two assistant secretaries, the USD(P&R) military deputy, and (in its role as an executive agent) the Army. Further, there were and are multiple and apparently overlapping oversight and coordination bodies. Although unity of command is a long way from being established within OSD for programs related to this problematic behavior, some progress has been made in this area, with the movement of DCoE from Army to DHA control.⁴⁷

Mission Focus

With the exception of the DDRP, organizations involved in substance use have a broad mission focus. The DDRP's long-time mission has been to test military personnel for illicit-drug use and incorporate new drugs into the test regime when they appear. However, addressing substance abuse makes up only a portion of the missions of medical and personnel management organizations. This might be appropriate from a medical perspective because SUDs are just one of many potential psychological health problems that can arise—and they are often linked to or are risk factors for other problematic behaviors. From the personnel management perspective, much of the organization and implementation occurs at the installation and command levels, with little OSD oversight related specifically to substance use.

Span of Control

In terms of span of control, DoD substance-abuse efforts cover a wide range of functions, including diagnosis and treatment in the medical community under the ASD(HA); prevention and part of enforcement under the DDRP and the military deputy to the USD(P&R) (now the executive director of the Office of Force Resiliency); and education, additional prevention, the remainder of enforcement, and disposition largely under line management, with some oversight by ASD(R&FM) (now ASD[M&RA]). However, these functions—from education to disposition—are comprehensively managed only by the USD(P&R) within OSD. That said, there is some degree of integration among the three LOEs at lower levels. For example, the diagnosis and treatment of SUDs are better integrated within the medical community as a result of the creation of the DHA and DCoE. In addition, the transfer of a service member's positive test result from the DDRP to the personnel management community is well-estab-

⁴⁶ Based on discussions with DSPO staff, August 15, 2014.

⁴⁷ Authority for the DDRP could also be transferred from the USD(P&R) military deputy to the new executive director of the Office of Force Resiliency.

lished, even though that transfer is managed differently in each of the services. However, DoD personnel noted that the medical community is being asked to take on increasing roles in areas outside diagnosis and treatment, although, for professional and cost reasons, it is resisting an expanded mission.

Organizational Collaboration

As for organization collaboration, several examples exist of collaboration between DoD organizations dealing with substance abuse and other problematic behaviors. As mentioned above, following a positive drug test, the DDRP and line management coordinate to move personnel into administrative and disposition channels. Also, the DDRP participates in Addictive Substance Misuse Advisory Committee meetings with members of the medical community, has established connections with other risky behaviors because of its placement under Personnel Risk Reduction, and participates in the Safety and Occupational Health Steering Group. In addition, medical and suicide prevention organizations regularly work together because of the strong correlation between substance misuse and suicide.

The services have been placing greater emphasis on changing the culture associated with alcohol consumption and smoking, reducing the stigma associated with counseling fellow service members about substance misuse, and encouraging personnel to self-identify risks or instances of potential substance misuse. Although this could lead to greater collaboration among the medical and line management communities, this is most likely to happen at the installation and command levels than in the higher reaches of DoD.

Planning and Assessment

The three functional communities that deal with substance abuse vary widely in their adoption of best practices in planning and assessment. Within the medical community, the DHA has submitted a draft strategic plan for all psychological health (of which substance abuse is a piece) to the Medical Deputies Action Group. It has some measurable goals, such as 100-percent adoption of screening in primary care, a unified medical record system, and use of evidence-based standards and treatment methods. The personnel management community does not appear to have a DoD-wide strategic plan or goals, but the services are generally moving toward a more holistic approach to problematic substance use that involves line management coordinating and collaborating with the medical community.

Of all DoD organizations, the DDRP has the clearest role and goals related to substance abuse. The DDRP's key performance output metric—testing rates across the services—clearly measures how the services are implementing the drug-testing program. However, in terms of a performance outcome metric, reducing positive test rates is more difficult to use as a robust measure of program effectiveness. Reasons for this include the following:

- Rapid changes in drug-use trends and new “designer” drugs mean that the testing does not capture all illicit-drug use.
- Service members might receive one drug test or fewer annually.
- Positive test results have a very low incidence, making it hard to correlate illicit-substance use with command training programs geared at prevention.

Resources

Given the diffuse character of its substance-abuse mission, it is difficult to determine the level of OSD's resources devoted to this problematic behavior, much less its sufficiency. Again,

the DDRP is an exception. Historically, the DDRP office has received a baseline budget of approximately \$120 million annually, with some supplementation from Congress for special programs or activities. However, this funding was projected to decrease in FY 2015 to approximately \$101.6 million. All the funding is executed through the services or DoD agencies and is mainly used for drug testing and for operating the drug-testing laboratories. According to the DDRP office, funding decreases could present challenges because the scope of testing over the past few years has increased, given the rapid introduction of new synthetic drugs and the increase in prescription drug misuse.

Four factors are largely responsible for influencing managerial practices in dealing with problematic substance use:

- the range of substances, behaviors, and effects on people involved
- the need to address the range of illegal uses, legal uses leading to illegal behavior, and completely legal uses of substances that can still negatively affect readiness
- the accretion of associated functions within DoD over time
- the lack of significant public and congressional focus.

Substance abuse is more complicated than other problematic behaviors because of the variety of substances (alcohol, drugs, and tobacco), the different ways problems arise from substance use, and the legal and illegal nature of the substances. Also, DoD has taken on more and more functions in the substance-use area over the years, with increased attention to prevention and treatment because of the repeated deployments to Iraq and Afghanistan. Further, although suicide prevention and sexual assault have garnered high-profile attention in recent years, substance abuse in DoD has not been subjected to significantly enhanced scrutiny, despite long-standing problems that have increased during the past decade. All these factors appear to have contributed to the development of the three separate communities that oversee and coordinate efforts.

Sexual Harassment and Unlawful Discrimination

The OSD organization responsible for sexual harassment and discrimination meets only two of our six managerial standards.

Unity of Command

Unity of command is ensured by the fact that sexual harassment and discrimination both fall under ODMEO's MEO program, which has a long history within OSD.

Mission Focus

Although the MEO program is focused on sexual harassment and discrimination, ODMEO has a much broader mission focus that includes outreach, diversity, and inclusion. MEO efforts are focused on being foundational and enabling the broader D&I efforts, yet problematic behaviors are not clearly delineated in ODMEO's mission.

Span of Control

Although the MEO program establishes anti-sexual harassment and antidiscrimination policy for the department, in terms of span of control, it is not resourced to actively oversee service policy compliance and implementation.

Organizational Collaboration

As for organizational collaboration, although the MEO program engages with the services on a somewhat regular basis in addressing sexual harassment and discrimination issues, organizational collaboration regarding efforts against sexual harassment and discrimination within OSD is limited and largely ad hoc.

Planning and Assessment

In terms of planning and assessment, the MEO program lacks a strategic plan against sexual harassment and discrimination, and DoD's D&I strategic plan is focused on promotion of diversity, EO, and inclusion rather than on countering negative behaviors.⁴⁸ However, ODMEIO's MEO working group does an effective job of bringing together MEO service leaders to collaborate on relevant issues.

Resources

A lack of personnel resources constrains ODMEIO's oversight and coordination of efforts against sexual harassment and unlawful discrimination. The former MEO program director had significant institutional knowledge and experience, but this position is not funded through ODMEIO and was vacant at the end of our research. Although ODMEIO and MEO leaders have relevant contacts, without a support staff, MEO's collaboration with OSD organizations is limited to SAPRO (whose relationship with ODMEIO is necessitated by NDAA requirements).

Two factors, in particular, influence the extent of MEO's managerial impact. First, although MEO has ownership over anti-sexual harassment and antidiscrimination policy, it does not currently exercise oversight of service MEO efforts. Second, although, during our research, ODMEIO was in the process of updating its DoD issuance that governs MEO, MEO is not resourced to support a broader mandate.

Hazing

The department's antihazing initiative is still under development; it is currently the least organizationally developed of the problematic areas in terms of managerial best practices.

Unity of Command

The fact that ODMEIO has unclear authority to oversee antihazing for DoD contravenes the principle of unity of command.

Mission Focus

Although hazing emerged as a hot issue that required a recent response to Congress, it is not an enduring mission focus for ODMEIO.

Span of Control

With ODMEIO restricted primarily to developing a response policy, it is unclear how ODMEIO's span of control might expand once the department's response to recent hazing events has had time to become more established.

⁴⁸ DoD, *Department of Defense Diversity and Inclusion Strategic Plan, 2012–2017*, Washington, D.C., April 19, 2012b.

Organizational Collaboration

Organizational collaboration for the antihazing effort is extremely limited. Collaboration with the services occurs through the hazing working group, but there is no evidence of collaboration with other OSD organizations.

Planning and Assessment

It is premature to evaluate OSD planning and assessment practices against hazing at this time, given the recent attention on hazing in the department and limited time to address these issues. That said, a February 2016 U.S. Government Accountability Office report stated that DoD as a whole has limited visibility into hazing incidents. Although most of the services track data on reported incidents of hazing, because tracking methods vary, the data are neither complete nor consistent.⁴⁹

Resources

Several factors have affected and could yet affect ODMEIO's ability to effectively manage DoD's antihazing initiative. In terms of personnel, the lead for antihazing efforts has changed hands at least three times since ODMEIO assumed responsibility for this problematic behavior. Additionally, realignment of the ODMEIO office and changes in senior leadership have affected the unity of command. Although the forthcoming antihazing policy that the hazing working group developed is supposed to outline antihazing roles and responsibilities, ODMEIO's expansive portfolio of missions and limited resources make its continuation as the hazing lead questionable. That said, ODMEIO leadership's extensive network of DoD connections could facilitate collaboration among organizations dealing with hazing and other problematic behaviors.

Comparison of Managerial Practices

Table 4.3 provides a side-by-side comparison of the results of our evaluation of the managerial practices of OSD organizations to address problematic behavior, based on the discussion above.

Summary

Our research looked across the OSD organizations responsible for addressing the six problematic behaviors, focusing on three questions: (1) What organizations are involved, and how are they structured? (2) What coordination and oversight mechanisms are currently being used? and (3) How well managed are OSD organizations addressing problematic behavior in terms of their conformity to recognized managerial principles?

It is difficult to make comparisons across a spectrum of organizations dealing with different problematic behaviors and aspects of behavioral mitigation and possessing different levels of authority, resources, and leadership emphasis. That said, the following list summarizes the

⁴⁹ U.S. Government Accountability Office, *DoD and Coast Guard: Actions Needed to Increase Oversight and Management on Hazing Incidents Involving Servicemembers*, Washington, D.C., GAO-16-226, February 9, 2016.

Table 4.3
OSD Management of Programs to Address Problematic Behavior

| Problematic Behavior | Unity of Command | Mission Focus | Span of Control | Organizational Collaboration | Planning and Assessment | Resources |
|---|--|--|---|---|--|--|
| Sexual assault | Authority centered in SAPRO; reports directly to USD(P&R) (+) | Singular focus on sexual assault (+) | Oversees full range of prevention and response activities (+) | Collaboration within and across problematic behaviors; capacity limits the potential for more (+) | Policy and authority well aligned; strategic plan ensures accountability (+) | Lacks resources for field visits; timeliness of funding is an issue (-) |
| Suicide | Program authority nominally centered in DSPO, but complex governance structure (-) | Singular focus on suicide prevention (+) | Prevention programs separated from messaging, health care, and policy (-) | High degree of collaboration within and across problematic behavior (+) | Strategic plan has clear objectives but lacks outcome measures, timelines, and resource requirements (-) | Funding projected to remain steady or increase; unable to fully execute FY 2013 budget (+) |
| Substance use | Authority split between ASD(HA), ASD(R&FM), and the USD(P&R) military deputy (-) | Each organization focuses on specific aspects of substance use (-) | Prevention, detection, treatment, and discipline not integrated (-) | Many coordinating bodies but limited collaboration outside focus area (-) | Strategic plan in draft; the DDRP has output (but not outcome) measures (-) | Total substance-use resources unknown; the DDRP budget is projected to decrease (-) |
| Sexual harassment and unlawful discrimination | Policy authority centered in ODMEIO's MEO program (+) | MEO focuses on problem areas; ODMEIO's remit is broader (+) | MEO is policy-oriented; not staffed for compliance oversight (-) | Limited and ad hoc outside focus areas (-) | No strategic plan for sexual harassment and discrimination (-) | MEO director position vacant; no support staff (-) |
| Hazing | No clear authorities (-) | Integration into ODMEIO's mission unclear (-) | Limited to response policy (-) | Extremely limited outside the services (-) | To be determined; new mission area | To be determined; new mission area |

NOTE: + = There is evidence that organizations are meeting managerial standards. - = There is evidence of significant managerial deficiency.

findings of our research into OSD organizations to address problematic behavior and their oversight, coordination, and managerial practices:

- **The organizational complexity of OSD efforts to address problematic behavior has varied considerably.** Until the establishment of the Office of Force Resiliency in late 2015 added a layer of bureaucracy, OSD's SAPR structure was quite simple, with SAPRO reporting directly to USD(P&R). By contrast, many OSD organizations at different levels of the bureaucracy continue to share responsibility for addressing substance abuse. OSD organizations dealing with other problematic behaviors fall in between these two extremes of complexity.
- **Coordination mechanisms are generally formal and often limited to a single problematic behavior; collaboration across problematic behaviors is usually informal, infrequent, and ad hoc.** Except for the hazing working group, all organizations to

address problematic behavior have OSD, other DoD, and, in some cases, non-DoD coordination partners and mechanisms that are used every few months or on an as-needed basis. Much of the coordination among organizations dealing with different problematic behaviors occurs in the form of informal interactions among staff members seeking specific types of assistance. The ad hoc nature of these collaborative activities is not necessarily bad and has resulted in useful outcomes in terms of reporting and data-sharing. Moreover, regular, formal interactions can be inflexible and inefficient. That said, discussants have indicated that they have little opportunity to engage in innovative forms of collaboration or develop new relationships outside their problem areas while still satisfying their current requirements.

- **Oversight authorities, policies, and plans are well delineated in some cases, numerous and confusing in other cases, and mostly lacking in one case.** Both SAPRO and DSPO have clearly focused directives and well-developed strategic plans that address SAPR and suicide prevention programs, respectively. There is a large amount of substance-use documentation; however, much of it is focused on drug testing and enforcement. ODMEIO has a directive that encompasses diversity, EO, and inclusion. Although it was developing an updated DoDI for MEO at the time of our research, ODMEIO lacks a strategic plan for programs to address unlawful discrimination and sexual harassment. There are currently no formal authorities or policies governing DoD's response to hazing. The various OSD oversight mechanisms dealing with sexual assault, substance misuse, and suicide prevention appear to be exercised on a regular basis. The MEO program and the hazing working group have produced status reports on military diversity and hazing when directed to do so, but there is currently no requirement to continue this kind of reporting. In general, OSD organizations to address problematic behavior have some metrics to evaluate the success of program efforts, but they tend to be more output than outcome oriented.
- **OSD's management conforms to organizational design principles more in some cases than in others.** It mostly conforms for sexual assault; conforms less for suicide prevention, substance abuse, unlawful discrimination and sexual harassment; and conforms not much at all for hazing, which is the least organizationally developed problematic-behavior area within OSD. Having said this, because of the inherent difficulty of comparing organizational designs that were developed to address different issues that exist within different medical, legal and policy environments, we cannot yet conclude that one organizational structure for mitigating problematic behavior is better than another.

Structural Alternatives for Addressing Problematic Behavior Within the Office of the Secretary of Defense

As OSD considers options for improving the coordination and oversight of policies and programs related to problematic behavior, a major issue is how and how much to adjust the existing departmental structure within the Office of the USD(P&R) to encourage better outcomes: for example, through clearer accountability, a greater sharing of limited resources, the identification of common goals and standards of measurement, and better collaboration in executing mutually supporting activities.

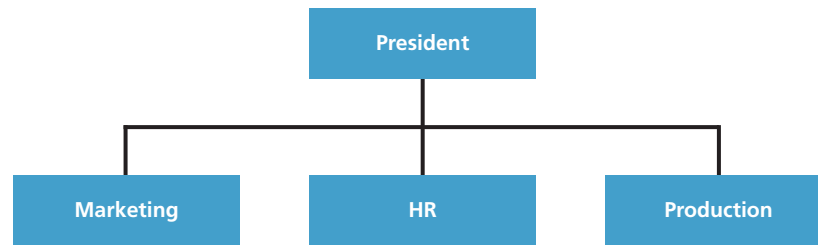
This chapter focuses on the question of what alternatives exist to OSD's current organizational structures that suggest ways OSD might improve its oversight and coordination of programs to address problematic behavior. To answer this question, we first explore the basic departmental alternatives outlined in the organizational design literature and indicate how the organizations that address problematic behavior in OSD conform to these generalized models. We then review actual alternative structures within the services and suggest how OSD might draw insights from the structural approaches the services are taking to better integrate their efforts for both decreasing the incidence of problematic behavior and enhancing the overall health and resilience of service members.

What Structural Alternatives Are Found in the Organizational Literature?

As described in the organizational design literature, there are two basic departmental structures—functional and self-contained—each of which has advantages and disadvantages.¹ In a functionally oriented organization, departments are arranged based on occupational skills. Thus, as Figure 5.1 shows, a business can have departments composed of specialists in marketing, production, finance, HR, and so on, whereas many military organizations have staff elements that focus on such things as operations, intelligence, personnel, logistics. Advantages of a functional departmental structure include ease of supervision, with most supervisory positions filled by persons with in-depth experience in a particular function, and an enhanced prospect that better skills will be applied to organizational problems. The greatest disadvantage of functional departments is that placing people together in specialized groups creates differences among groups even while instilling solidarity within a group. Consequently, greater attention is needed to promote integration between departments to ensure, for example, that they do not pursue objectives that are at odds with one another. Because all functions must be

¹ For an analysis of the effects of various types of departmental structures, see Robey and Sales, 1994.

Figure 5.1
Functional Departments in a Manufacturing Company



SOURCE: Adapted from Robey and Sales, 1994, p. 185.

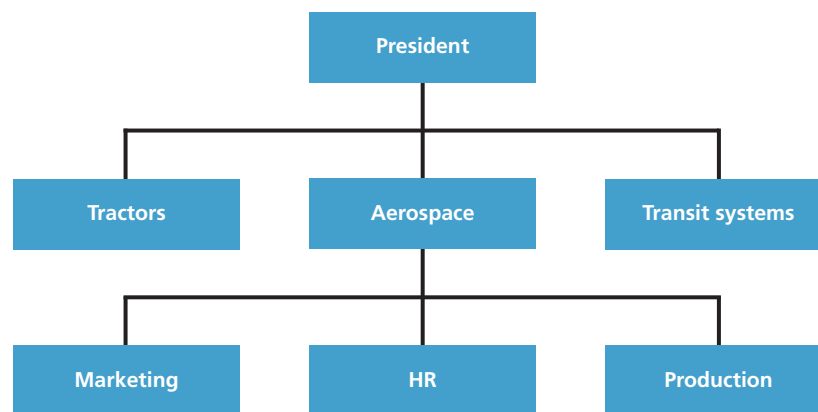
RAND RR1352-5.1

performed for the overall task of an organization to be accomplished, another disadvantage is the difficulty of establishing responsibility for performance.

By contrast, self-contained divisions are fairly autonomous, with each division containing all the functional skills needed to perform its tasks. Although there are several ways to implement a self-contained design, the primary way is through product or service differentiation. Thus, an aerospace group in a corporation or an armored division in the military has all the functions it needs to support the delivery of the product or service (see Figure 5.2). An advantage of self-contained structures is that coordination problems are simplified because resources need only be applied to one product or service. Another advantage is that a self-contained structure permits top managers to assess good and poor performance because each division is responsible for a single output category. Disadvantages include the duplication of resources in each department and reduced opportunities for resource-sharing, as well as decreased specialization of input skills given that personnel focus more on outputs. Finally, self-contained departments tend to compete with one another, which can inhibit collaboration or lead to a misallocation of talent or resources.

In practice, most large and complex organizations contain examples of various departmental structures. Team-based designs, such as matrix organizations, try to retain the benefits

Figure 5.2
Self-Contained Product Departments in Manufacturing



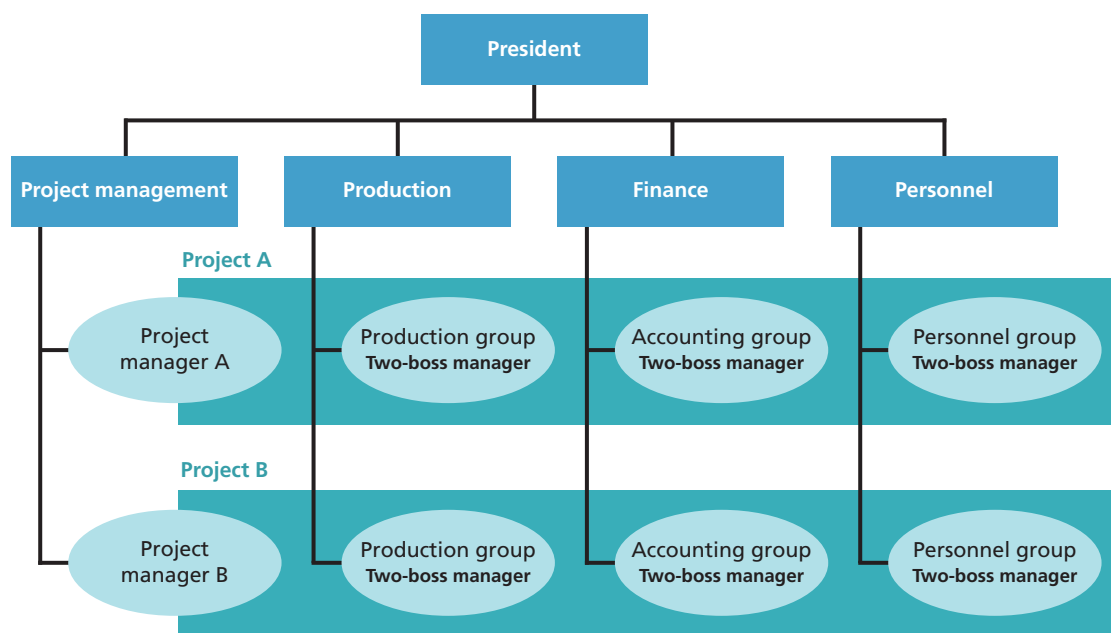
SOURCE: Adapted from Robey and Sales, 1994, p. 188.

RAND RR1352-5.2

of functional specialization while finding ways to coordinate specialized resources around specific tasks. As Figure 5.3 illustrates, two lines of authority exist in a matrix structure: a functional line that runs vertically (from functional departments, such as production, finance, and personnel, to functional groups) and a second line that runs horizontally from project managers to the functional groups, connecting specialists who work on the same project. Thus, a member of a functional group has two bosses: the functional department head and a project manager. Although this model violates the classic principle of unity of command, the dual authority of the matrix structure is intended to strike a balance between two organizational needs: ensuring technical quality through its vertical hierarchy and enforcing efficient application of resources through its horizontal lines of project or program authority. However, achieving such a balance is not easy. Many businesses have reportedly abandoned matrix structures in recent years because of conflicts between functional and project managers, excessive administrative overhead, and slow decisionmaking resulting from multiple information flows.²

OSD's organization of the offices responsible for policies and programs to address problematic behavior represent a mix of structural types. In broad terms, the structure can be described as functional in that personnel working on issues related to problematic behavior all ultimately report to a functional executive—that is, the USD(P&R). However, oversight and coordination responsibilities for several behaviors are more or less self-contained. As previously noted, SAPRO was created to be the “single point of authority” for SAPR policy and accountability within DoD.³ The director of ODMEQ serves as the senior manager for the

Figure 5.3
Matrix Organizational Structure



SOURCE: Adapted from Robey and Sales, 1994, p. 222.

RAND RR1352-5.3

² Robey and Sales, 1994, p. 224.

³ SAPRO, “Mission and History,” undated.

MEO program, which provides oversight to DoD efforts to prevent discrimination and sexual harassment among military personnel. By contrast, personnel focusing on substance-abuse issues are currently mostly assigned to functional elements of OSD's bureaucracy that fall under the ASD(HA) and ASD(M&RA). The one relatively self-contained organization in the substance-abuse area is the DDRP, a component of the Office of Personnel Risk Reduction. The organizations that oversee OSD's suicide prevention activities are both functional and self-contained. DSPO is the principal coordinator of suicide prevention plans and programs, but policymaking responsibility is shared with the ASD(HA) and the Office of Force Resiliency. As discussed earlier, responsibility for DoD's antihazing policy has yet to be officially defined—although ODMEIO is currently the coordinating authority. In short, OSD lacks a consistent structure for the oversight and coordination of efforts to address the problematic behavior we have examined.

What kind of structural design would appear to work best to improve overall accountability, collaboration, goal-setting, or the sharing of resources? From a theoretical perspective, the answer is that it depends on what OSD's leadership is trying to accomplish through structural reform. For example, a functionally based organization would probably be most suitable if retaining a skilled and experienced workforce were considered essential. If integrating workforce activities and holding people accountable were preeminent considerations, some form of self-contained organization structure would seem appropriate. Alternatively, a matrix structure might be the solution if there is a need to strike a balance between having the right expertise to formulate good policies and establishing clear responsibilities and common standards for policy execution.

Alternative Structures Within the Services

One actual source of alternative structural models is provided by the services, which, like OSD, have an obligation to address problematic behavior and have recently taken steps to establish a more coherent approach to the management of a broad range of behavioral programs. This section focuses on the question of what OSD might learn from how the services deal with problematic behavior. Keeping in mind the differences in OSD and service responsibilities for managing problematic behavior, we first describe examples from the Army, Navy, Marine Corps, and Air Force of structural adaptations intended to provide a better departmental response to behavior issues affecting service members and their families. We then examine the potential usefulness of these examples to OSD as it considers organizational changes to improve its oversight and coordination of efforts to address problematic behavior among military personnel throughout DoD. However, it should be noted that limited time, resources, and information, as well as the changing nature of service behavior organizations, led us to refrain from rendering judgments about their effectiveness. Also, as Chapter Four demonstrates, organizational design is only one factor to consider when analyzing an organization's coordination and oversight capabilities.

The approach used in this part of the research is based on information primarily gleaned through policy discussions (both in person and by telephone) with personnel across Army,

Navy, Marine Corps, and Air Force programs that address problematic behavior.⁴ It draws on the same protocol used with OSD (see Appendix B) and discussed in Chapter Four.

How Are the Services Structured to Address Problematic Behavior?

When we look at the organizations in the services that deal with problematic behavior, no single structural design predominates. Although each service has program offices that focus on specific behaviors—such as illegal discrimination, sexual assault, sexual harassment, and drug testing—and report to counterpart offices in OSD,⁵ each has established somewhat different structures for integrating behavioral program activities and initiatives. Nevertheless, there is a trend that is especially evident in the Army and the Navy and, to a lesser extent, in the Marine Corps and Air Force, toward developing self-contained structures intended to facilitate the coordination and oversight of multiple behavioral efforts; this trend reflects a more holistic approach to service members' health and readiness. We describe some of these organizations below. Also described below is an Army example of a shift in functional authority for a behavioral program that had adverse consequences. Finally, we discuss how the Air Force has established a matrix-like organization for addressing behavioral issues.

Self-Contained Programs in the Army, Marine Corps, and Navy

Self-contained behavioral structures come in various forms in the services. Beyond the basic building block—a program focusing on a single behavior—the services have developed structures that attempt to integrate efforts that address multiple problematic behaviors, as well as behaviors that are positive (beneficial to readiness, resilience, and health) and negative.

Army Programs

Coordinating Army Readiness Programs

The Army's shift to an integrated and whole-person approach to behavioral health is encompassed in the Army's Ready and Resilient (R2) Campaign that was announced in late 2012. R2 is for the Total Army: soldiers in the active component, Army National Guard, and U.S. Army Reserve, as well as soldier families and Army civilians—an acknowledgment that success in the battlefield is beyond training and weapons for soldiers. R2 is itself not a program. Considering the proliferation of Army programs in the past decade, the purpose of the R2 Campaign is to look “holistically and strategically” at the Army's R2 initiatives and to consolidate guidance for programs that aim to improve soldier, family, Army civilian, and unit readiness.

To execute R2, the Army created ARD in November 2013. Its mission is to improve formal coordination among programs and move toward a comprehensive, integrative approach in awareness, prevention, treatment, and rehabilitation. Its responsibilities include development of policies, doctrines, plans, budgets, and initiatives for these programs, as well as overall implementation, relevant research, evaluation, and assessment. It is also responsible for developing and overseeing databases, such as the Army's Sexual Assault Data Management System; for preparing reports; and for collating statistics for submission to senior leaders in the Army and OSD for reporting to Congress and the White House. As of March 2015, ARD reported

⁴ The study team also reviewed service documents related to the management of programs to address problematic behavior that were publicly available or provided to us by those with whom we spoke.

⁵ See Appendix C for a description of the service programs to address problematic behavior.

having initiated formal coordination with numerous programs, including those for the problematic behavior covered in this study.⁶

In direct support of the R2 Campaign is the Army Health Promotion Program. At the community level, it is a leadership program that works to encourage lifestyles that “improve and protect physical, behavioral, and spiritual health” by implementing programs and services at the community level—that is, the installation, regional, or state level.⁷ Another support mechanism is the Risk Reduction Program (RRP)—a tool for commanders to reduce high-risk behavior among their soldiers⁸ that grew out of the Army Substance Abuse Program (ASAP) that U.S. Army Installation Management Command (IMCOM) oversees and executes at an installation level. The RRP does not create new services. Instead, it brings a prevention-focused approach to deal with problematic behavior, including suicide, sexual assault, and substance abuse.

The Marine Corps’ Integrated Behavioral Health Program

The Marine Corps approach to reducing problematic behavior is characterized by integrating efforts, with a focus on unit-based approaches and creating training that aims to be effective and efficient. In particular, the Marine Corps deliberately combined efforts focused on suicide prevention, family advocacy, substance abuse, operational stress control, and sexual assault into the Behavioral Health Program in 2010.

The Behavioral Health Program is the main coordination and oversight mechanism for addressing problematic behavior within the Marine Corps. The Marine Corps model views many of the problematic behaviors included in these programs as interrelated and as having the potential to occur together and to build toward very negative outcomes. Especially in the presence of triggers, such as permanent change of station or other transitions,⁹ relationship breakdowns, disciplinary actions, job-related stress, or substance abuse, this model recommends increased vigilance and the use of protection factors found in training and education to prevent suicide attempts (and other problematic behaviors). The Behavioral Health Program model also recognizes a series of demographic risk factors—in particular, young males of junior enlisted ranks are at risk for a wide variety of potentially destructive behaviors. Also, the model explicitly recognizes that the use and misuse of alcohol are associated with many other problematic behaviors and spill over into many other behaviors; examples provided include motorcycle safety and sexual assault.¹⁰ Therefore, the Behavioral Health Program model attempts to deal with all these behaviors in an integrated fashion. Best practices include embedding clinical

⁶ ARD officials with whom we spoke do not rule out the possibility of the Army’s SHARP program coming under ARD in the future; for now, it remains under a separate chain of command under the G-1.

⁷ Author phone conversations with senior Army officials involved in the R2 Campaign, October 9, 2014, and November 13, 2014.

⁸ The RRP originated as a reengineering effort at Fort Campbell, Kentucky, in 1994 to address a series of high-risk incidents.

⁹ In particular, transitions have been noted as being a “high-risk area” that is linked to suicides. In the Marine Corps, behavioral health personnel are currently planning to begin working more closely with the Personal and Professional Development Program, which is one of many DoD programs that offer transition assistance.

¹⁰ According to our interviews, those working on problematic behavior within the Marine Corps report that OSD’s highly stovepiped approach to alcohol- versus drug-related issues means that having an integrated approach at the service level is more difficult; in particular, OSD’s funding requirements are thought to be restrictive.

providers at the marine expeditionary force or unit level (similar to the Army's Risk Reduction Program coordinators).

To integrate behavioral health programs, the Marine Corps elected to combine program personnel by functional area rather than discipline; in particular, the policy analysts from each program now work together as a team, as do the data analysts from each program. This has allowed better integration of both data and policy. Integrating the data analysts was viewed as a necessity, both to better advocate for resources and to track progress more holistically. Behavioral health personnel also report having built logic models for their programs and tracked a variety of measures. Of course, they track such negative outcomes as suicides, family violence, and DUIs, as well as a variety of outputs, such as training completed. A memorandum of understanding with the Wounded Warrior Project, a nonprofit organization dedicated to assisting injured veterans, enables behavioral health programs to use an existing data platform to track key outputs and outcomes. Program managers are trying to determine how to measure the success of their integration efforts. A key long-term goal is to develop ways to evaluate combined, unit-level training programs that cover all relevant problematic behavior.

Coordinating Navy Readiness Programs

As is the case in the U.S. Army, the Navy's approach to combating problematic behavior is integrated and holistic, based on a deliberate decision to organize all relevant programs into a single office, the 21st Century Sailor and Marine Office (N17). This office includes a wide range of programs that deal with many aspects of readiness. The Navy's approach to addressing problematic behavior is characterized by viewing behaviors along a spectrum and by focusing efforts on establishing the right climate at the command level. Within the Navy's organizational structure, N17 is part of the Office of the Chief of Naval Operations (OpNav).¹¹

N17 includes six branches (or programs):

- Total Sailor Fitness (drug and alcohol prevention, as well as numerous programs that deal with physical readiness and family readiness, including transition support)
- Suicide Prevention and Operational Stress Control
- SAPR
- Sexual Harassment Prevention and Equal Opportunity
- Behavioral Standards (hazing and fraternization)
- Policy and Resource Coordination.¹²

Personnel focus is on the command level. The commander is viewed as holding responsibility for establishing and maintaining the correct "climate," and problematic behavior is viewed as occurring most frequently when the climate allows this. To some extent, this command-centric view might reflect the varied circumstances in which sailors serve (on submarines, on aircraft carriers, on smaller ships, on shore, in overseas locations).¹³ Personnel in N17

¹¹ The Chief of Naval Operations (CNO), the Vice Chief of Naval Operations, the Deputy Chiefs of Naval Operations, and certain other ranking officers and their staffs are collectively known as OpNav.

¹² The specifics of the establishment of N17, and the organization of branches within, are drawn from Chief of Naval Operations, "Establishment of Navy's Twenty-First Century Sailor Office (OpNav N17)," Naval Administrative Message (NAVADMIN) 153/13, April 2013, and Nicole Battaglia, director, 21st Century Sailor and Marine Office, "21st Century Sailor Office," briefing to the authors, May 2014. Also see Appendix C for more information on this office.

¹³ Indeed, one discussant stated that there are five separate navies: ships, subs, special ops, cyber, and onshore.

view consolidated training within all N17 codes (or as many N17 codes as is practical) to be both effective and efficient. Their goal is to have training that is not redundant so sailors actually spend less time in training but gain more useful information.

Along with improving training, personnel in N17 view establishing consistent and integrated sources of data as central to their efforts. Another theme across the policy discussions involved the tone of messaging to the fleet. Personnel within N17 strive to create positive messages because they believe that these messages are best received and are most likely to be effective.

Functional Responsibility: Substance Abuse in the Army

Despite the trend in the services toward more-expansive, self-contained organizations to improve coordination and oversight of various behavioral programs, functional lines of authority are still very important in determining how programs are managed in certain behavioral areas. This is particularly the case for substance abuse in the Army.

As the proponent for ASAP, G-1 is responsible for integrating, coordinating, and approving all pertinent policies. The director of the Human Resources Policy Directorate provides guidance and leadership on all nonclinical alcohol and drug policy issues through the director of ASAP. The director of ASAP directs the operation of the Army Center for Substance Abuse Programs. As such, the director is responsible for (1) developing ASAP goals and policies; (2) developing, establishing, administering, and evaluating nonclinical alcohol and other drug abuse prevention, education, and training programs and reviewing, assessing, and recommending policy changes; (3) interpreting ASAP policies for the Army and in response to queries from organizations outside the Army; (4) preparing budget submissions, allocating funds, and monitoring execution of resources for ASAP; and (5) overseeing the Army's drug and alcohol testing program.¹⁴

In 2010, IMCOM took over lead responsibility from the Office of the Surgeon General (OTSG) for implementing substance-abuse policy, working closely with Army commanders to ensure that all officials and supervisors support execution of prevention and treatment activities.¹⁵ Although the rationale for the change in implementation leadership is not entirely clear, the Army's decision was presumably based on a belief that substance abuse within the military is primarily an administrative issue to be handled by installation commanders and their staffs rather than primarily a health issue to be managed by medical professionals.

Although defining the right balance of functional responsibility for substance-abuse policy execution is a matter for further analysis, there is considerable evidence in press reports that the Army's transfer of substance-abuse outpatient treatment from medical to nonmedical leadership in 2010 coincided with a decline in the quantity and quality of care for service members seeking help for substance abuse and related problems, the departure of experienced personnel from Army facilities, and substandard managerial practices at substance-abuse clinics. According to a *USA Today* investigative report, evaluations by senior clinic staff members showed that as many as half of the 7,000 soldiers who were refused treatment in 2014

¹⁴ Clinical treatment for substance abuse is MEDCOM's responsibility, as defined in MEDCOM, *Medical Services: Medical Review Officers and Review of Positive Urinalysis Drug Testing Results*, MEDCOM Regulation 40-51, March 30, 2005.

¹⁵ Other Army entities involved in implementing ASAP are medical review officers, the staff judge advocate, the military police and U.S. Army Criminal Investigation Command, unit prevention leaders, and base area code program managers, who oversee drug testing and training.

after being screened for potential drug or alcohol problems should have been treated; 27 of the Army's 54 substance-abuse clinics fall below professional standards for treating drug and alcohol abuse; and many psychologists and social workers who served as counselors or clinical directors at a broad swath of Army bases have resigned, retired, or transferred to other jobs since the change in command responsibility for substance abuse, contributing to a significant shortage of clinical staff. In the view of critics of Army substance-abuse policy, a major source of these problems stems from a lack of understanding among functional managers without medical training of the consequences to Army health and readiness of leaving a substantial number of soldiers untreated—something for which medical professionals, they believe, have a keen appreciation.¹⁶

Matrix Structure: The Air Force's Matrix-Like Structure for Behavioral Organizations

Although the Air Force is reportedly considering further steps toward organizational integration,¹⁷ it currently lacks an overarching self-contained organization in the Air Force comparable to the Army's ARD or the Navy's N17 that is responsible for overseeing and coordinating a broad range of behavioral programs and activities. Instead, the Air Force has a multilayered set of intra-agency oversight and coordination organizations—CAIBs, Integrated Delivery Systems (IDSs), and Comprehensive Airman Fitness (CAF)—and a central point of contact in Air Force headquarters. This organization is matrix-like in that it contains a mix of interconnected functional and self-contained elements.

CAF, CAIBs, and the IDS provide venues for intraservice coordination and oversight of initiatives pertaining to problematic behavior and overall airman well-being. Established in 2011, CAF is modeled on the Army's larger and longer-running Comprehensive Soldier and Family Fitness program. Currently made up of one airman and one civilian located in Air Force headquarters and two full-time training staff members stationed off-site, CAF manages the agenda and actions of the Air Force CAIB (chaired by the assistant vice chief of staff) and the training program for the Master Resilience Trainers, who provide wing-level services to airmen for improved resilience.¹⁸ Because of their small number, CAF personnel are limited in the amount of direct coordination they can do.

The CAIBs and IDSs are oversight and coordination forums for the entire range of issues related to the well-being of Air Force personnel, and they exist at all levels of the Air Force hierarchy. The CAIBs exercise their oversight responsibilities by bringing together management leads from such areas as manpower (at the headquarter level) and unit or installation commanders (at lower levels) who oversee the delivery of services to address problematic behavior. The IDSs are composed of functional leads from the service-provider organizations. For example, at the installation level, the IDS members would include the EO lead for the installation. Each CAIB and IDS reports formally (though not as line management) to the next CAIB and IDS up the Air Force hierarchy.

The Air Force CAIBs and IDSs, which are the headquarters-level groups, ultimately report to the Air Force Chief of Staff, Vice Chief of Staff, and Assistant Vice Chief of Staff (AF/CVA). The headquarters-level CAIB is chaired by AF/CVA—with the CAF lead serving

¹⁶ Gregg Zoroya, "Investigation: Army Substance-Abuse Program in Disarray," *USA Today*, March 12, 2015.

¹⁷ RAND phone interviews with Air Force SAPR and suicide prevention office officials, August 2016.

¹⁸ Chief, Airman and Family Care Division, *Special Management: Community Action Information Board (CAIB) and Integrated Delivery System (IDS)*, Air Force Instruction 90-501, October 15, 2013, incorporating change 1 August 14, 2014.

as the CAIB executive director—and the members include all the Air Staff heads (e.g., Deputy Chief of Staff for Manpower, Personnel and Services [AF/A1]), staff leads from the Air Force Secretariat organizations, and the IDS chair. This organization meets at least two times per year and considers issues that cannot be resolved by the IDS, CAF, and lower-level CAIBs and IDSs. The headquarters-level IDS meets at least quarterly to consider Air Force-wide issues related to the delivery of services intended to improve airman readiness, resilience, and well-being. IDS functional leads (including those from organizations to address problematic behavior) propose changes or solutions, which are referred to the CAIB for ultimate decision. In some cases, issues are assigned by the CAIB; in other cases, they are raised by IDS members or lower-level CAIBs and IDSs. The IDS chair is appointed by AF/CVA from among the IDS members on a rotational basis.

The establishment of the CAIB, the IDS, and CAF reflect an acknowledgment by Air Force leadership that problematic behavior and other issues affecting airman well-being often have significant overlap and might be better addressed in an integrated fashion. Additionally, the multilayered structure of the CAIBs and IDSs is designed to (1) solicit more insights from installations and functional levels at which services are delivered and (2) provide more feedback about headquarters-level actions. One specific issue requiring a more integrated service response is “survey fatigue,” which results from a lack of coordination among different levels of Air Force management and different functional organizations. According to one discussant, the staff working for AF/A1 has made recent efforts to combine surveys and to make each survey’s purpose clear up front—resulting in higher response rates. And Air Force leadership, in turn, is purportedly trying to reference surveys and other analytic mechanisms that were used as the impetus for institutional changes to demonstrate the benefits of and build support for these data-collection efforts.

Insights for the Office of the Secretary of Defense from Analysis of the Structural Alternatives in Military Departments

We began this chapter by discussing three alternative departmental structures: self-contained, functional, and matrix. Given that the OSD organizations that address problematic behavior represent a mix of structural types, we asked the question whether one type might work better than others. The answer we gave was that it depends on what the leadership wants to achieve, in that each basic structural design is most consonant with certain organizational objectives, such as better expert advice, staff retention, greater accountability, increased collaboration and resource sharing, or all the above. That said, if the preeminent issue is integration of policy-making regarding problematic behavior (i.e., improved oversight and coordination), one or more self-contained structures with clear chains of command and common plans of action would seem preferable. But, in the absence of strong research evidence about the interconnections among risks and prevention strategies related to problematic behavior, which behavioral activities and programs should fall within the purview of existing or new self-contained structures? Furthermore, how should these structures relate to different functional authorities (primarily health officials and personnel managers) with significant stakes in, different responsibilities for, and divergent perspectives on behavioral problems, such as substance abuse within the military? Although bifurcated lines of authority and layers of coordinating committees

have been the default remedies in such cases, as shown in Chapter Four, it is not clear that they have aided the cause of integration.

Our research team turned to the services for real-world structural examples and lessons that might be applied to OSD's situation. Although we acknowledge that service responsibilities are different from those of OSD—the latter being more focused on program implementation and the former being more focused on policymaking—one should not make too much of this distinction. Service headquarters have considerable leeway for setting internal policies and must oversee and coordinate activities of organizations that are larger and more complex than most corporations. Thus, it is not misguided to view them as potential models for OSD as it considers structural changes to improve the integration of its efforts to address problematic behavior. Moreover, the services have been more active than OSD in recent years in making structural changes designed to promote collaboration across a range of programs to address problematic behavior.

It is true that programmatic stovepipes still exist in the services for a variety of reasons; these include separate authorizations and funding lines, differences in the way the law is applied to certain behaviors as opposed to others, and the reporting requirements that OSD has established. But there has been a concerted effort to create more and more-expansive self-contained behavioral organizations in the military departments. Although little research has been conducted on the results of these initiatives, the rationale for increased coordination across behavioral categories seems justifiable if only to understand common risk and prevention factors, the potential for common approaches to prevention and training to address problematic behavior, and the possibility of distributing resources to where they are most needed. This rationale would seem to apply to OSD and the services, particularly if the various self-contained organizations could be aligned in a way that would decrease rather than increase the number of service reporting requirements. However, a cautionary note is warranted. An advantage we found in our research of one OSD organization, SAPRO, is its laser-like focus on a single problematic behavior. By contrast, ODMEQ, with admittedly fewer resources, seems less able to manage its larger basket of behavioral issues. Thus, it is important that any new OSD structures designed to consolidate policymaking authority over behavioral programs not weaken existing program initiatives that have demonstrated positive results.

The relevance to OSD of our findings about the functional authority over the Army's substance-abuse program and the Air Force's matrix approach to behavioral management are less evident than our findings on the trend toward larger self-contained structures in the Army and Navy, in particular. Although the shift of substance-abuse authority from the Army OTSG to IMCOM has reportedly been associated with a decline in care and an exodus of professional staff, the authority in question relates to policy execution (specifically, the management of substance-abuse clinics) rather than policy guidance, with the latter being OSD's principal area of responsibility. As Chapter Four showed, though, the management of substance-abuse policy is more confusing than any other aspect of OSD's behavioral portfolio, and one reason for the confusion is the need to balance the responsibilities and interests of the medical and personnel management communities. Thus, no central authority deals with substance abuse within OSD; rather, several different authorities and numerous bodies coordinate policymaking and reconcile divergent points of view. This leads us to the matrix organization that the Air Force employs to integrate various functions related to a range of health and readiness issues. If one accepts the Air Force's contention that its intersecting CAIB/IDS structure works well, that structure could serve as a model for OSD of how to manage behavioral issues that do not read-

ily fit within the confines of a self-contained organization with a unified authority structure—by having staff members report to functional and program management. An added advantage of a matrix structure is that it could make it easier to deal with emerging behavioral issues by allowing functional experts to be shifted from one program team to another while still remaining under the umbrella of an established behavioral organization. However, as the Air Force’s reported desire for further integration attests, a self-contained organization is more likely than a matrix organization to produce the coherent vision and clear-cut accountability mechanism needed to confront the significant behavioral issues affecting the military.

Conclusions and Recommendations

There is a strong motivation and considerable momentum behind OSD's current search for an integrated solution to a range of problematic behaviors among members of the military. On a political level, DoD and administration leaders understandably want to effectively confront problematic behavior before it becomes a contentious issue that surfaces in the press and that is a subject discussed by Congress and the general public; this was the case for sexual assault and suicide in recent years. On an institutional level, there is a deep concern about the state of military morale and readiness after a decade and a half of persistent conflict followed by budgetary and personnel reductions. If DoD is to continue to recruit and retain top-quality people, the institution obviously cannot be perceived as indifferent to suffering within its ranks. For their part, officers and noncommissioned officers within the services are under considerable pressure to meet a variety of requirements related to training and administration to address problematic behavior, some of which they view as redundant or at least not mutually reinforcing. In combination, these factors have led to a growing DoD consensus that there has to be a better way of managing the spectrum of existing and emerging problematic behaviors while fostering behaviors that strengthen the mental and moral capacities of individuals and organizations. This has been the driving force behind such initiatives as the Army's R2 Campaign and the Navy's N17, as well as the Joint Staff High-Risk Behavior Working Group. However, despite the increasing preference for a combinatorial approach to behavior problems within the military, there has been little analysis on which behaviors should be dealt with collectively and how DoD should manage its numerous programs to address problematic behavior.

This concluding chapter examines the issue of integrating, at the OSD level and from a research perspective, programs to address problematic behavior. It does this by building on the evidence that we have collected and analyzed through our review of the scientific literature on risks and prevention strategies related to problematic behavior, our policy discussions with OSD and service headquarters officials who oversee and manage efforts to prevent problematic behavior, our review of documents related to DoD strategies and programs to address problematic behavior, and our survey of organizational design theory and practice to answer the two remaining questions posed in the report's introduction:

- To what extent should programs to address problematic behavior be integrated?
- Assuming that programs should be integrated, in what ways should that integration occur?

Behavioral Research Conclusions and Recommendations

According to our review, the existing academic literature cannot serve as a guide for determining the full extent of desirable integration of programs to address problematic behavior within OSD. Not so differently from the Pentagon with its penchant for organizational stovepiping, the scientific community has tended to study problematic behaviors in isolation from one another. Nevertheless, our analysis does present considerable empirical evidence about general risk factors that exist *across* multiple behaviors—that is, attitudes about problematic behavior, a social or organizational climate that fosters or discourages problematic behavior, and access to the means to engage in problematic behavior. Furthermore, our research shows that these factors have been or could be targeted by multidimensional prevention strategies that address (1) the propensity to engage in problematic behavior through screening, education, and attitude-modification programs; (2) ways to inhibit problematic behavior—related changes to organizational norms and culture, bystander programs, access to mental health treatment, and policy innovations; and (3) the means to engage in problematic behavior through various legal and administrative actions. Finally, the fact that we have identified few academic studies that examine the relationships across multiple problematic behaviors suggests the need for OSD to take the lead in conducting such research to provide an evidentiary basis for its organizational approach to enhancing the health and well-being of service members and their families.

The rest of this section summarizes our key research findings with respect to risk and protective factors and prevention strategies related to problematic behavior and provides recommendations on how OSD might take action in response to what we have learned from our review of the scientific literature on selected problematic behaviors. Given the breadth and complexity of some of these recommendations and the need for substantial cooperation throughout the department to ensure that they are effectively carried out, we suggest that the USD(P&R) create a senior-level task force, chaired jointly by the USD(P&R) military deputy, the new executive director of the Office of Force Resiliency, the ASD(HA), and the ASD(M&RA) and including representatives from the military services, NGB, and relevant defense agencies, which would be responsible for issuing guidance on improving the integration of OSD's efforts to address problematic behavior within the military and for overseeing the implementation of such guidance.

Risk Factors

We developed a conceptual model that placed the risk factors related to the six problematic behaviors into three categories: propensity to engage, disinhibition, and access to means. Attitudes seem to predict problematic behavior best when organizational context also supports the behavior. In other words, someone is more likely to engage in problematic behavior, such as sexual harassment or hazing, if he or she perceives that his or her employer explicitly or implicitly condones his or her actions. Conversely, someone who initially might be inclined toward problematic behavior can be dissuaded if the organizational climate is clearly in opposition to such behavior. Another finding is that limiting access to the means for performing a problematic behavior (e.g., alcohol, guns, relationship of authority) can prevent the behavior (e.g., alcohol misuse, suicide, sexual harassment) from occurring. This calls for an approach that addresses the propensity to engage in problematic behavior, disinhibition of problematic behavior, and access to the means to engage in problematic behavior.

Our last finding is that the scientific literature provides linkages among certain problematic behaviors. For example, alcohol use is a risk factor for suicide and sexual assault, and recent RAND research on sexual assault has demonstrated its association to sexual harassment and hazing. However, the stovepiped nature of academic research has meant that there have been relatively few studies on the interrelationships among multiple problematic behaviors.

It should be noted that our review of risk factors was not intended to be exhaustive. Given our mandate to investigate potential areas for collaboration across agencies, we adopted a conservative approach, limiting our review to settled, replicated science. The scientific knowledge base on risk and protective factors is still growing, and greater understanding is needed with respect to the full set of unique and overlapping factors that can reliably predict problematic behavior.

Given these risk-factor findings, we offer the following recommendations to the Office of the USD(P&R) as focus areas for the proposed DoD task force for integrating programs to address problematic behavior:

- As an initial priority, review existing assessment systems that monitor the role of cultural factors (e.g., shared values) and climate factors (e.g., shared perceptions about tolerance of sexist jokes) in promoting or inhibiting problematic behavior and modify these systems that have coverage gaps or methodological problems. Give special attention to emerging problematic behavior, such as hazing and unlawful discrimination and harassment of lesbian, gay, bisexual, and transgender personnel. DEOMI's Organizational Climate Survey (DEOCS)—which DoD commanders use to assess EO, organizational effectiveness, and perceptions of discrimination, sexual harassment, and SAPR—would seem to be the appropriate tool for understanding the relationship between the organizational environment and the incidence of problematic behavior. However, the DEOCS has certain limitations that would need to be overcome before its results could be considered scientifically valid.¹
- Review existing service policies that are intended to restrict access to the means to engage in problematic behavior—for example, the Navy has worked with commissaries and other stores on base to limit hours for sale of alcohol—and consider applying those policies that been shown to be effective to other parts of DoD.
- Consider ways to leverage existing DoD data—for example, from the Workplace and Gender Relations Surveys and Health Related Behaviors (HRB) Survey—to explore connections among problematic behaviors. When possible, consolidate surveys that address various problematic behaviors, and ensure that survey questions target factors that enable such behaviors. In cases in which data are insufficient, consider recommending the expan-

¹ The study team has several concerns about the validity of DEOCS findings. First, the sampling plan for the DEOCS is problematic. Because sampling is not random and conditions of the survey administration might not be acceptable, many opportunities exist for systematic biases to be introduced into the results. The survey is conducted only when the commander agrees to have it done. More troubling is the fact it is not necessarily offered to everyone in the unit nor to a truly random sample of unit members. Second, the DEOCS approach to assessing some aspects of climate is known to be invalid. For instance, the assessment of sexual harassment simply asks about observations of “sexual harassment” in the unit. Most people are unclear about the definition of sexual harassment, so the validity of their responses is going to vary with their understanding of the law and regulations that pertain to this term. Third, DEOCS officials claim a 50-percent response rate, but it is not certain what this means given the sampling approach. Even if this percentage is correct, there is a real risk of nonresponse bias in the survey results. Normally, this would be partially addressed via sample weighting. However, we have seen no evidence that DEOCS analyses use sample weighting.

sion or adaptation of promising data-collection tools currently in use that monitor risks for multiple behaviors, such as the Air Force's combined suicide risk-tracking system.

Prevention Strategies

Our research on the literature related to prevention strategies suggests that combined prevention strategies relying on common principles could be developed and evaluated for multiple problematic behaviors. Although holistic prevention strategies have only recently been adopted within the military, there is some precedent for combined risk-tracking across problematic behaviors to guide the delivery of indicated prevention programs: in particular, the Air Force's suicide risk-tracking program. Methods found to be effective for preventing or responding to a specific problematic behavior might also be effective when adapted for other behaviors. However, because of the traditional tendency of scientists and practitioners to focus on single behaviors, as well as for behavioral research and program implementation funding to be distributed unevenly, prevention strategies have not usually been evaluated for their applicability to different problematic behaviors. Of course, employing similar prevention strategies to address multiple problematic behaviors makes sense only if the methods used are effective. The results of our literature review indicate few instances in which specific programs or practices have had a measurable impact on reducing the incidence of a problematic behavior; however, they do point to areas of strategic convergence and potential gaps along the prevention spectrum at which program and research efforts might be applied, with the hope that a multidimensional, integrated approach might work better than a singular, disconnected strategy.

The following recommendations for the Office of the USD(P&R) and the military services derive from our prevention strategy findings:

- As a priority, evaluate the effects of prevention and response strategies that DoD is currently using to cope with individual problematic behaviors on other behaviors. Although there are issues with current methods of evaluating the impact that such strategies can have on problematic behavior, it nevertheless makes logical and financial sense—if DoD decides to evaluate a prevention program for a particular problematic behavior, such as hazing—that DoD also measure how it might influence other behaviors, such as sexual assaults.

Programmatic Analysis Conclusions and Recommendations

Our qualitative analysis of OSD and service programs to address problematic behavior suggests the need to consider modifications to how OSD oversees and coordinates efforts to prevent problematic behavior. OSD programs to address problematic behavior vary substantially in terms of unity of command, mission focus, span of control, collaboration, quality of planning and assessment processes, and adequacy of resources. In some ways, this is neither surprising nor necessarily inappropriate. An organization's design is contingent on the environment in which it operates—that is, the kind of problems it addresses, the extent of its responsibilities, and the priority accorded to it. Nevertheless, our discussions with program officials and review of existing policy and strategy documentation indicate that some of the practices that OSD employs to address certain problematic behaviors do not conform to basic managerial

principles. Accordingly, we have proposed steps to bring the management of these problematic behaviors into closer alignment with best practices.

The findings from our research into structural alternatives for addressing problematic behavior are less prescriptive than they are suggestive of approaches that OSD could take once the leadership has formulated a comprehensive vision for behavioral health and readiness based on an improved understanding of the interconnections among behavioral risks and prevention and promotion strategies. According to organizational design theory, self-contained structures, which focus on products or services and contain all the functional elements necessary to perform their tasks, are better suited to achieving oversight and coordination objectives than functionally based organizations are. However, theory does not provide a good answer to the question of how large these self-contained structures should be or how closely controlled their individual product or service elements should be.

As our analysis of service headquarters organizations shows, the trend is toward the development of self-contained structures that encompass multiple behaviors pursuant to a holistic strategy that promises both better health and readiness outcomes and a better allocation of limited resources. Still, larger structures, such as ARD, are mostly designed for coordination purposes. Thus far, individual service programs to address problematic behavior continue to have separate reporting chains that are connected to their counterpart offices in OSD. It is possible that a broad self-contained structure at the OSD level could facilitate both coordination and oversight of behavioral efforts throughout the department. But, to do so effectively and efficiently, it would need to align its roles and responsibilities with comparable service organizations and overcome authority and funding issues that constrain certain programs' ability to integrate their activities and share resources. Furthermore, its leadership would need to ensure that their efforts to encourage cross-program collaboration did not dilute existing organizations' focus on addressing particular problematic behaviors.

The rest of this chapter summarizes our specific programmatic findings and provides recommendations on improving OSD oversight and coordination of programs to address problematic behavior.

Oversight

Some OSD organizations that are responsible for overseeing DoD's efforts to deal with problematic behavior—sexual assault, in particular—have most of the managerial tools necessary to perform the roles assigned to them. However, other organizations—including those responsible for unlawful discrimination and sexual harassment, suicide, and substance abuse—lack adequate policies, plans, information systems, and resources needed to establish a departmental approach to certain behavioral issues, to inform senior leadership about these problems, and to ensure that the leadership's decisions with regard to problematic behavior are being uniformly enforced. Hazing, especially, represents a significant gap in OSD's framework for mitigating problematic behavior. Although ODMEIO is chairing a working group charged with addressing this issue and has recently issued a memo that more clearly defines this problematic behavior, OSD still does not have a policy that spells out how the services and other defense organizations are to reduce the incidence of hazing.

There is also a need for better OSD-supervised tracking and accountability mechanisms for problematic behavior. In the Army, for example, only formal (written and sworn) sexual harassment complaints are reported up the chain of command, while informal complaints are resolved at the lowest possible level and not tracked, which hampers understanding of the

extent and nature of the problem. Also, our discussions with OSD and service officials indicate that personnel and funds for some efforts to address problematic behavior are being stretched to the point at which mandated tasks cannot be done or cannot be done well within specified time periods. This is particularly the case in OSD's MEO office, in which a single person has had nominal oversight responsibility for all DoD programs that address sexual harassment and discrimination issues among military service members. Without a permanent support staff, however, MEO has had difficulty issuing up-to-date policy guidance, much less ensuring policy compliance.

OSD's complex governance structures for tackling suicide and, especially, substance abuse within the military also inhibit effective oversight. Although designated as the focal point for suicide prevention policy, DSPO was under the operational control of the USD(P&R), resourced by DHRA, and received guidance from three different governing boards during the period of our research. Furthermore, other OSD organizations are responsible for important suicide-related functions, such as messaging on suicide prevention-related issues and the health care-related aspects of suicide prevention. Whereas suicide prevention at least has a central programmatic authority, albeit a weak one, the arena of substance-abuse policy is, for the most part, functionally organized; it contains no self-contained structure except for the drug-testing program. This diffusion of responsibility across health, personnel management, and other functions makes it inherently difficult to craft a comprehensive behavioral strategy or to establish a mechanism for monitoring policy compliance and behavioral outcomes in all the functional areas pertinent to substance abuse.

These findings lead to the following recommendations for the Office of the USD(P&R) that are intended to improve the oversight of OSD organizations to address problematic behavior:

- As an initial priority, ensure that DoDDs and DoDIs are issued that establish responsibilities for achieving objectives for addressing problematic behavior, monitoring progress, and coordinating activities.
- Also as a priority, ensure that a strategic plan for addressing sexual harassment is developed and that the substance-abuse strategic plan is completed. Ensure that all strategic plans dealing with problematic behavior contain specific objectives, realistic milestones, essential tasks, and meaningful and measurable expected outputs and outcomes. Also, ensure that plans are aligned within a problematic area and with other relevant DoD and service plans.
- Approve a DoD definition of hazing, and establish policies and procedures for reducing the incidence of hazing. Review and reevaluate ceremonies that could be sanctioned hazing.
- Develop clear and common definitions, standards, and submission protocols for behavior data that the services collect and report to OSD.
- Examine the pros and cons of establishing an OSD program that would have policy and oversight responsibility for prevention of and response to substance (including alcohol) abuse within DoD, including the activities currently carried out by the DDRP.
- Consider increasing DSPO's authority to oversee suicide prevention programs in DoD organizations, including requiring the services to provide data to DSPO on suicide prevention program performance and effectiveness.

Coordination

Currently, OSD does not have a single organization that is responsible for coordinating efforts to prevent, treat, and respond to the range of problematic behaviors examined in this report. Instead, many OSD offices address certain functions related to certain behaviors. In part, this is understandable given that the expertise and the authority to perform certain functional activities involving problematic behavior reside in specific organizations and cannot be easily combined within one OSD entity. In addition, although RAND's recent research on sexual assault has demonstrated the relationship between this problematic behavior and sexual harassment, as well as hazing, there is limited research on the connections among several of the problematic behaviors we reviewed. That said, the argument for improved coordination of organizations within OSD to address problematic behavior is supported by the fact that DoD has only so many resources to devote to overseeing departmental efforts aimed at addressing problematic behavior, and these resources are distributed widely and unevenly. Thus, a more coordinated approach could be helpful from the standpoint of cost and benefit if there were more and broader evidence of risk-factor linkages and programmatic effects on multiple behaviors.

Obstacles to coordination exist among OSD organizations dealing with issues pertaining to individual and multiple behaviors. As just mentioned, an overly complicated management structure hampers substance-abuse policy development and implementation. To bring together various functional interests, multiple coordinating bodies have been established at different levels of the department. Also, the complex governance structure for suicide prevention within the USD(P&R) has constrained the office's ability to coordinate the activities of programs that target this problematic behavior. Furthermore, existing bureaucratic processes and varying levels of resources do not enable OSD organizations focused on different but related problematic behavior, such as sexual assault and sexual harassment, to easily work with each other. As a result, OSD treats behaviors separately, for the most part. By contrast, although they still retain individual offices for each problematic behavior, the services (in particular, the Army and the Navy) are beginning to undertake a holistic approach to behavior management.

To improve the coordination of efforts to address problematic behavior, we recommend the following to the Office of the USD(P&R):

- As a priority, consider streamlining OSD management of certain problematic behavior—in particular, abuse of substances (including alcohol) and suicide—by consolidating working groups and senior steering groups and assigning clear responsibility for coordinating policies related to awareness, prevention, treatment, response, and evaluation, either by establishing self-contained programs or by developing a well-defined matrix structure with functionally integrated programs whose personnel report to both senior functional and program managers.
- Review OSD coordinating bodies and activities to understand where the gaps might lie with respect to collaboration to address problematic behavior. Explore where formal and informal collaboration can best support important objectives and tasks, and obtain explicit support from the leadership for significant collaboration initiatives.
- Encourage services to monitor and evaluate innovative holistic approaches to behavioral management and to share lessons learned from them, as the Army has announced its intention to do with respect to its R2 Campaign.

In sum, OSD can do much to improve its organizational response to existing and emerging problematic behaviors. With some notable exceptions, there is little definitive scientific research on connections among problematic behaviors. Therefore, pursuing integrated solutions to behavioral problems in OSD should be treated as testable experiments at present. In addition, OSD should take steps to improve how its offices oversee and coordinate DoD efforts to address particular behaviors by completing policies and plans, expanding tracking and accountability mechanisms, establishing self-contained programs with wider oversight responsibilities, and consolidating coordinating bodies without decreasing collaborative opportunities. A high-level, permanent body responsible for overseeing and coordinating policies and programs to prevent problematic behavior might make sense at some point in the future and should be explored in cases in which behavioral linkages are clear. However, if OSD leaders decide on such an approach, they should first review the lessons learned by service headquarters organizations responsible for integrating programs designed to curtail problematic behavior and increase the resilience of service members.

Prevalences of Six Problematic Behaviors Within the Military

In this appendix, we present data showing the prevalence of the six problematic behaviors discussed in this report, with a focus on prevalence within the military. The prevalences here are in line with the definitions of the behaviors shown in Chapter One. As noted, in the main report, we focus the review on risk for, and prevention of, engaging in problematic behavior. However, when estimating prevalence of problematic behavior, it is often more useful to gather this information from victims, who tend to be less biased sources of information, than from perpetrators, who might not be fully transparent when describing their problematic behavior. For sexual harassment, sexual assault, unlawful discrimination, and hazing, we use victim reports to estimate the prevalence of the problematic behavior among service members.

Sexual Harassment

According to the most recent comprehensive survey of active-component service members, 1.7 percent of women in the services and 0.4 percent of men experienced a quid pro quo violation in the past year, and 21.4 percent of women in the services and 6.6 percent of men experienced a sexually hostile work environment in the past year.¹

Sexual Assault

According to the most recent comprehensive survey of active-component service members, 4.9 percent of women in the services and 0.9 percent of men were sexually assaulted in the past year.² Fifteen percent of women in the services and 2 percent of men have experienced at least one sexual assault at some point in their military careers.³

With respect to co-occurrence with other problematic behavior, there is evidence of overlap between sexual assault and sexual harassment: About one-third of service members who have been sexually assaulted in the past year indicated that the offender had sexually harassed them before or after the sexual assault.⁴ Women who indicated being sexually harassed in the past year are 14 times more likely to indicate experiencing sexual assault in the past year than

¹ NDRI, 2014.

² NDRI, 2014.

³ NDRI, 2014.

⁴ NDRI, 2014.

women who indicated not being sexually harassed; men who indicated being sexually harassed are 49 times more likely to indicate experiencing a sexual assault.⁵ Although military-specific data on sexual assault and suicide are not available, data from epidemiological surveys of civilian women suggest that the risk for suicide attempts is 13 times greater among survivors of sexual assault than among non-crime victims.⁶

Unlawful Discrimination

According to the most-recent statistics available, about 16 percent of minority active-component service members report experiencing harassment or discrimination based on race or ethnicity in the past year.⁷ Also, 12 percent of all service members reported experiencing discrimination on the basis of their age in the past year.⁸ A more recent survey of active-component service members found that 12.4 percent of women in the services and 1.7 percent of men experienced gender discrimination in the past year.⁹ Unlike sexual harassment, gender discrimination does not necessarily involve behaviors of a sexual nature.¹⁰ For example, discrimination against women can include being excluded from male social groups, being left out of important decisionmaking discussions, or being given lower-level assignments than men, none of which is an explicitly sexual behavior.¹¹

Substance Abuse

According to DoD HRB Surveys of military personnel conducted from 1980 to 2008,¹² rates of heavy alcohol use (i.e., five or more drinks per occasion at least once per week) significantly increased from 1998 (15 percent) to 2008 (20 percent). However, the 2008 rate (20 percent)

⁵ Andrew R. Morral, Kayla Williams, Coreen Farris, and Kristie L. Gore, "The 2014 RAND Military Workplace Study," in Andrew R. Morral, Kristie L. Gore, and Terry L. Schell, eds., *Sexual Assault and Sexual Harassment in the U.S. Military*, Vol. 1: *Design of the 2014 RAND Military Workplace Study*, Santa Monica, Calif.: RAND Corporation, RR-870/1-OSD, 2014, pp. 1–6.

⁶ National Victim Center and Crime Victims Research and Treatment Center, *Rape in America: A Report to the Nation*, Arlington, Va.: National Victim Center, April 23, 1992.

⁷ Natalie Namrow, Elizabeth Van Winkle, Lisa Davis, and Phil Masui, *2013 Workplace and Equal Opportunity Survey of Active Duty Members*, Alexandria, Va.: Defense Manpower Data Center, Report 2014-040, October 2014.

⁸ Rock, 2013.

⁹ NDRI, 2014.

¹⁰ O'Leary-Kelly et al., 2009.

¹¹ O'Leary-Kelly et al., 2009.

¹² Robert M. Bray, Michael R. Pemberton, Laurel L. Hourani, Michael Witt, Kristine L. Rae Olmsted, Janice M. Brown, BeLinda Weimer, Marian E. Lane, Mary Ellen Marsden, Scott Scheffler, Russ Vandermaas-Peeler, Kimberly R. Aspinwall, Erin Anderson, Kathryn Spagnola, Kelly Close, Jennifer L. Gratton, Sara Calvin, and Michael Bradshaw, *2008 Department of Defense Survey of Health Related Behaviors Among Active Duty Military Personnel: A Component of the Defense Lifestyle Assessment Program (DLAP)*, Washington, D.C.: U.S. Department of Defense, RTI/10940-FR, September 2009; Robert M. Bray, Michael R. Pemberton, Marian E. Lane, Laurel L. Hourani, Mark J. Mattiko, and Lorraine A. Babeu, "Substance Use and Mental Health Trends Among U.S. Military Active Duty Personnel: Key Findings from the 2008 DoD Health Behavior Survey," *Military Medicine*, Vol. 175, No. 6, June 2010, pp. 390–399.

is comparable to rates in 1980 (21 percent), when the survey began. Correspondingly, rates in binge drinking (i.e., five or more drinks per occasion for men, four or more for women, at least once in the past month) increased from 1998 (35 percent) to 2008 (47 percent).¹³ Compared with a national U.S. sociodemographically matched sample, active-duty service members ages 18 to 35 were significantly more likely than their civilian counterparts to have engaged in heavy drinking.¹⁴

According to the 2008 HRB Survey of active-duty military personnel, the rate of past-month illicit-drug use was 2.3 percent for military personnel, compared with 12 percent for civilians. Rates were higher for both populations, 3.9 percent military and 17 percent civilians, among those ages 18 to 25. However, according to 2008 estimates, rates of prescription medication abuse are higher among service members (11 percent) than the civilian population (4 percent).

High rates of co-occurrence between SUDs and mental health problems have been established. As cited in an IOM 2013 report, rates of co-occurring SUDs and mental health problems have ranged from more than half of Operation Enduring Freedom and Operation Iraqi Freedom veterans with SUDs and PTSD diagnoses to more than 80 percent of veterans with SUDs also having accompanying mental health problems (e.g., PTSD, depression).¹⁵

Suicide

Suicide rates are commonly presented as the estimated number of suicide cases per 100,000 people in the population. In 2012, suicide was the tenth-leading cause of death in the United States, with a rate of 12.6 suicides per 100,000 members in the population that year.¹⁶ To understand how military suicide rates compare with those in the U.S. population as a whole, Ramchand and his colleagues (Ramchand et al., 2011) derived adjusted suicide rates for a synthetic national population that was matched to the demographic profile of DoD personnel for the years 2001 to 2006.¹⁷ Suicide rates for the synthetic civilian population were considerably higher than they were for the military population. Adjusted suicide rates for the U.S. population remained slightly below 20 suicides per 100,000 in the U.S. population, whereas rates for the DoD were approximately ten suicides per 100,000 people in the DoD population for each year during the period. However, Ramchand et al., 2011, notes that significant increases in DoD suicide rates occurred in 2007 (13.8 suicides per 100,000 population) and 2008 (16.3 suicides per 100,000 population), with rates in 2008 being higher than between 2001 (10.3 suicides per 100,000 population) and 2005 (11.3 suicides per 100,000 population) and with the most-significant increases seen for the Army.¹⁸ In a recent DoDSER, the suicide rate for the active component for all services was 18.7 per 100,000 for 2011, 22.7 per 100,000

¹³ Bray, Pemberton, Hourani, et al., 2009.

¹⁴ Bray, Pemberton, Hourani, et al., 2009.

¹⁵ IOM, 2013.

¹⁶ Jiaquan Xu, Kenneth D. Kochanek, Sherry L. Murphy, and Elizabeth Arias, *Mortality in the United States, 2012*, Atlanta, Ga.: National Center for Health Statistics, Data Brief 168, October 2014.

¹⁷ Ramchand et al., 2011.

¹⁸ Ramchand et al., 2011.

in 2012, and 18.7 per 100,000 for 2013.¹⁹ For service members in the reserve component (including active and non-active duty), suicide rates appeared to climb over time (18.1 in 2011, 19.3 in 2012, and 23.4 in 2013). Similarly, for service members in the National Guard (including active and non-active duty), suicide rates also seemed to increase over time (24.8 in 2011, 28.1 in 2012, and 28.9 in 2013).

When relevant, this report also includes reports on suicide attempts and suicidal ideation. CDC defines a suicide attempt as “a non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior,” which might or might not result in injury.²⁰ CDC devised definitions for self-directed fatal and nonfatal violent behaviors that did not include suicidal ideation. Suicidal ideation has been defined as “thoughts of harming or killing oneself.”²¹

Suicide has been found to co-occur with mental health problems and SUDs. A high percentage of people who die by suicide have indications of mental health problems,²² and between 20 and 30 percent have evidence of being legally intoxicated at the time of death.²³ However, it is important to note that the large majority of people with mental health problems and SUDs do not die by suicide. For instance, estimates of lifetime risk of suicide range from 4 percent of people with mood disorders²⁴ to 7 percent of those with alcohol disorders.²⁵ Table A.1 shows co-occurrence of suicide and behavioral health diagnoses and histories.

Table A.1
Co-Occurring Factors in Service
Members Who Died by Suicide, All
Services, 2013

| Factor | Percentage |
|-------------------------------|------------|
| Behavioral health diagnosis | 40 |
| History | |
| Substance abuse | 21 |
| Sexual abuse victim | 3 |
| Sexual abuse perpetrator | 7 |
| Sexual harassment victim | <1 |
| Sexual harassment perpetrator | 2 |

SOURCE: Reger et al., 2015.

¹⁹ Reger et al., 2015.

²⁰ Crosby, Ortega, and Melanson, 2011.

²¹ Goldsmith et al., 2002.

²² Cavanagh et al., 2003.

²³ Goldsmith et al., 2002.

²⁴ John Michael Bostwick and V. Shane Pankratz, “Affective Disorders and Suicide Risk: A Reexamination,” *American Journal of Psychiatry*, Vol. 157, No. 12, December 2000, pp. 1925–1932.

²⁵ Barbara Schneider, 2009.

Hazing

Estimates of hazing prevalence in the military are unclear. Some services have not tracked reported hazing incidents, and those that have have not done so uniformly. Additionally, hazing has not been included as a topic in DoD-wide surveys in the past. However, questions about experiences with hazing were recently added to the revised 2014 DEOCS and to the RAND Military Workplace Study, which queries whether sexual assault incidents were hazing-related.²⁶ Results of the 2014 DEOCS have not been publicly released.²⁷ Among victims of military sexual assault surveyed in the RAND study, however, 34 percent of male victims and 7 percent of female victims indicated that the sexual assault was part of a hazing incident.²⁸ Estimates of hazing prevalence in the civilian population vary. One study estimates that more than half of college students involved in clubs, teams, and organizations experience hazing.²⁹ Evidence of co-occurrence with other problematic behavior is extremely limited, as is empirical research on hazing more generally.

²⁶ Morral et al., 2014.

²⁷ For more information on the DEOCS, see DEOCS, home page, undated. It is important to note that the DEOCS does not sample in a manner that would provide a representative DoD-wide estimate of hazing prevalence.

²⁸ NDRI, 2014.

²⁹ Allan and Madden, 2008.

Interview Protocol

In this appendix is the protocol that the study team used to conduct approximately 45-minute policy discussions with approximately 75 OSD and service headquarters officials responsible for overseeing and managing programs focused on the six problematic behaviors examined in this study.

Data-Collection Protocol for Programs to Address Problematic Behavior

Good morning [or afternoon], [title, name].

Thank you for accepting our request for a conversation to learn about your program.

I am [name, title] with the RAND Corporation. RAND is a nonprofit, independent, policy research organization. RAND has been around for more than 60 years, and we have had a long relationship providing research and analytical support to the Office of the Secretary of Defense, the services, and many other federal and state government organizations.

As was mentioned in our email request to your program, the director of the Office of Diversity Management and Equal Opportunity, Under Secretary of Defense for Personnel and Readiness, has asked the RAND National Defense Research Institute to conduct a study aimed at developing a cross-service framework to facilitate collaboration among DoD special issue programs focused on problematic behaviors within the military.

Today's meeting [conversation] should be about 45 minutes, covering six broad themes. The information we collect will only be used for the problematic-behaviors framework study. There are no right or wrong answers. We want to make sure we get the facts right and benefit from your expert knowledge about the program.

Are there any questions for us before we begin?

Let's start with the fundamentals . . . the mission, goals, and resources of your program.

Mission, Goals, and Resources

- mission and goals of the program
 - What is your program's mission, and what are its key goals?
- origin of program
 - When was your program established? What motivated its establishment? For example, was the program established due to a congressional mandate? By order of the Secretary of Defense? An outgrowth or replacement of an existing program?
- funding (add "source and type of funding")

- What is the source or type of funding for your program?
- What is the annual budget for your program? Has this changed significantly over time?
- Where do the bulk of the funds go (e.g., staff salary, outreach to and services for service members and dependents, or research, publication and dissemination)?
- To what extent are your current or planned funding levels appropriate for implementing your mandated activities?

Next, let's discuss your program's authorities and organization.

- authority and reporting structure [**probe**]
 - What directive, policy, or regulation provides legal authority for your program?
 - Who or what office does your program report to in the executive branch?
 - What agencies or organizations do you have oversight responsibility for?
 - How do laws and policies affect the extent to which problematic-behavior efforts can be integrated?
 - Does legislation, such as the NDAA or another congressional mandate, require reports related to your program?
 - How frequently does your program report? In what form?
 - What information (if any) do you need from the services or other agencies for these reports?
 - Are there any challenges in collecting this information?
- leadership, staffing, and organization
 - Who are the senior leaders of your program? Civilian and/or military?
 - What are the major divisions or groupings in your program? (org chart if possible)
 - How many full- and/or part-time staff or contractors support the program?
 - Has this number remained steady, grown, or fallen in past several years?
 - Is this number anticipated to hold steady, grow, or fall in the coming years?
 - Do you feel that your current staffing levels are appropriate for implementing your mandated activities?

Next, let's turn to your program's strategic plans and program activities.

- strategic planning
 - Does your program have a strategic plan? What are the goals or initiatives? [**probe**]
- program responsibilities and key activities
 - What are the key responsibilities and activities for your program overall?
- interactions with other programs
 - What other programs or offices does your program closely interact or work with? (Within OSD? Within your service? With other services? With other behavioral areas) Please focus on those most critical to achieving your mission and goals. [**probe**]
 - What is the nature of the interactions? (formal/informal and frequency of interaction)
 - oversight and reporting
 - working groups
 - conferences or summits
 - data-sharing
 - joint campaigns or projects

- other liaison activity.
- Have the organizations your program works with and nature of relationships changed over time? Please describe these relationships. **[probe]**
- What challenges do you face in coordinating with other organizations? (formal or informal barriers, resource restraints, bureaucracy, etc.)
- Do you see any opportunities to leverage partnerships or coordination with other organizations?

Another area we are keen to learn about is how program performance and success are evaluated.

Measures of Performance and Success

- internal measures and metrics
- What key metrics and measures does your program use to assess performance and success? How do you collect data? How are the data/analysis used and maintained? **[probe]**
- Considering there are numerous DoD and service programs working on various behavioral health problems, what are your thoughts on how they can best work—independently and in collaboration—to achieve their respective mission and goals? And doing this with sensitivity to resource considerations and the needs of target populations?
- external measures and metrics
 - What metrics and measures, if any, does your program employ to satisfy formal reporting requirements?

And the last area of query today is whether you could speak to any important current and/or anticipated challenges to your program.

- What additional challenges does your program face currently or anticipate in meeting its mission and goals? How is your program responding to them? (Budget/resources/staffing? Leadership turnover? Lack of or constraints imposed by policy or regulations? Others?)

Finally, are there other officials in your program or contacts for organizations with which your program works closely with whom we should talk (in OSD or in the services)?

This concludes the major questions we have for your program at this point. Is there anything you'd like to add at this time? And in case anything comes to mind, please feel free to contact me [provide your contacts].

Service Organizations to Address Problematic Behavior and Perspectives on Office of the Secretary of Defense Oversight and Coordination

The focus of our programmatic research was on understanding how DoD as a whole organizes itself to deal with problematic behavior, with the goal of determining ways to improve its organization, coordination, and oversight in addressing the behaviors. In Chapter Four, we discussed the key results of that effort. However, we also decided to look at how the services manage the same problematic behavior in their organizations. The goal here, however, was not to evaluate the services' management practices like we did for the DoD-wide organizations; rather, it was to explain the ways in which the services are organized to address problematic behavior. In this appendix, we provided detailed descriptions of service behavioral organizations.¹ Chapter Five provides a synthetic, high-level summary drawn from this material.

Approach

The material in this appendix is based on information primarily gleaned through policy discussions (both in person and by telephone) with personnel across Army, Navy, Marine Corps, and Air Force programs that address problematic behavior.² However, as was the case in the other research, we also consulted other primary and secondary sources as appropriate. For example, we studied any relevant directives, strategic plans, and other formal documentation. In some cases, personnel involved in our policy discussions provided this information; in other cases, we located the documents prior to holding the policy discussions. We draw on the same protocol used with OSD and discussed in Chapter Four (see Appendix A). As a reminder, the protocol addresses five general topics: (1) mission, goals, and resources; (2) authorities and organization; (3) strategic plans and program activities; (4) measures of performance and success; and (5) current and anticipated program challenges.

For each service, we selected the organizations that have primary oversight for each of the six problematic behaviors included in our study. We then requested that personnel in those organizations take part in our policy discussions (which followed the protocol included in Appendix A). In each case, service personnel were responsive to our request.

¹ As part of our analysis of service organizations, we spoke with members of NGB, as the joint component of the Department of the Army and the Department of the Air Force. The Army National Guard and the Air National Guard make up the National Guard, which is part of the reserve component of the U.S. armed forces. Because those discussions did not substantially affect the assessment related to the two questions, we do not include full explications in this chapter; however, we include specific comments where relevant.

² The study team also reviewed service documents related to the management of programs to address problematic behavior that were publicly available or provided to us by those with whom we spoke.

Although bullying is not one of the six problematic behaviors that are the focus of this study, we included some discussion of it because antibullying work is sometimes a part of the work of the organizations we examined. As of the fall of 2015, there was no separate defense policy or program to address bullying, but several service directives explicitly prohibit bullying and require commanders to prevent and report this problematic behavior.

With the Army, our focus was on the following programs: (1) the SHARP program; (2) the Army Directorate of Psychological Health, Behavioral Health Division; (3) the Army Suicide Prevention Program; (4) Army EO; (5) ASAP; and (6) ARD.

With the Navy, our discussants included personnel working across the programs, including those within the N17; personnel working specifically on sexual harassment and EO, hazing, and SAPR; and suicide prevention and operational stress control.

With the Marine Corps, we focused on discussions with personnel in the programs included within behavioral health, as well as SAPR, hazing, and sexual harassment and discrimination.

With the Air Force, we focused our policy discussions on people within the following programs: (1) CAF, (2) the DDRP, (3) Air Force EO, (4) the Office of the General Counsel, (5) the headquarters-level IDS, (6) the Air Force Medical Support Agency, (7) SAPR, and (8) the Suicide Prevention Program.

How Are the Services Organized to Address Problematic Behavior?

In this section, we briefly discuss how each of the services is organized to address problematic behavior.

Army Programs to Address Problematic Behavior

The Ready and Resilient Campaign and the Army Resiliency Directorate

In the past several years, the Army has shifted to embrace an integrated and whole-person approach to behavioral health, even though separate programs continue to exist for individual problematic behaviors. This shift is rooted in the Army's new emphasis to enhance personal and institutional "resilience" for operational readiness as the ultimate goal rather than simply treating each problematic behavior or focusing on individual soldier well-being.

This shift is embodied in the Army's R2 Campaign that was announced in late 2012. R2 is for the Total Army: soldiers in the active component, the Army National Guard, and U.S. Army Reserve, as well as soldier families and Army civilians—an acknowledgment that success on the battlefield is beyond training and weapons for soldiers. R2 is itself not a program. Considering the proliferation of Army programs in the past decade, the purpose of R2 is to look "holistically and strategically" at the Army's R2 initiatives and to consolidate guidance for programs that aim to improve soldier, family, Army civilian, and unit readiness.³

To execute R2, the Army created ARD in November 2013. Its mission is to improve formal coordination among programs and move toward a comprehensive, integrative approach in awareness, prevention, treatment, and rehabilitation. Its responsibilities include developing policies, doctrines, plans, budgets, and initiatives for these programs, as well as overall imple-

³ Author phone conversations with senior Army officials involved with the R2 campaign on October 9, 2014, and November 13, 2014.

mentation, relevant research, evaluation, and assessment. It is also responsible for developing and overseeing databases, such as the Army's Sexual Assault Data Management System; for preparing reports; and for collating statistics for submission to senior leaders in the Army and OSD for reporting to Congress and the White House. As of March 2015, ARD reported having initiated formal coordination with numerous programs, including those for the problematic behaviors covered in this study.⁴

In direct support of the R2 is the Army Health Promotion Program. At the community level, it is a leadership program that works to encourage lifestyles that “improve and protect physical, behavioral, and spiritual health”⁵ by implementing programs and services at the community level—that is, the installation, regional, or state level. AR 600-63, *Personnel: General—Army Health Promotion*, sets forth responsibilities for all aspects of the program. Operationally, Community Health Promotion Councils are central to implementing the program, taking integration and alignment of resources and responses from Headquarters, Department of the Army (HQDA), to the community level in implementing R2. Resources and staffing for Community Health Promotion Councils are determined by the General Officer Steering Committee under ARD.

Another support mechanism is the RRP—a tool for commanders to reduce high-risk behavior among their soldiers⁶ that grew out of ASAP, which IMCOM oversees and executes at an installation level. RRP does not create new services. Instead, it brings a prevention-focused approach to deal with problematic behavior, including suicide, sexual assault, and substance abuse. The G-1 has responsibility for ensuring that RRP interfaces with offices and programs in the Army, DoD, and civilian agencies to coordinate and implement actions to prevent high-risk activities. Operationally, installation RRP coordinators and mission commanders at installations meet every quarter to review battalions' risk profiles. RRP coordinators work with mission commanders to determine appropriate interventions, such as getting the chain of command to address issues of unit culture and ensuring that installation expertise and services are being fully utilized.

Because this approach and the mechanisms created to support it are fairly new—taking shape and being implemented as we conducted our study—it is too early to tell how well they serve to address the problematic behavior examined in this study.

Sexual Harassment and Sexual Assault

Unlike OSD, the Army has a single program for sexual harassment and SAPR, with an emphasis on prevention. Until 2008, separate programs existed for sexual harassment and sexual assault, with an emphasis on response.⁷ The mission of the combined SHARP program is to

⁴ ARD officials with whom we spoke do not rule out the possibility of the Army's SHARP program coming under ARD in the future; for now, it remains under a separate chain of command under the G-1.

⁵ Author phone conversations with Army senior officials involved with the R2 campaign on October 9, 2014, and November 13, 2014. Also see “Ready and Resilient,” undated home page.

⁶ The RRP originated as a reengineering effort at Fort Campbell, Kentucky, in 1994 to address a series of high-risk incidents.

⁷ Importantly, besides the SHARP program under the G-1, several other Army organizations also have roles in SAPR based on their missions and special capabilities. Among others, MEDCOM, *Medical Services: Medical Facility Management of Sexual Assault*, MEDCOM Regulation 40-36, December 23, 2004, requires MEDCOM “to provide timely, accessible, and comprehensive medical management of sexual assault victims . . .” Headquarters, Department of the Army, *Legal Services: Military Justice*, Washington, D.C., AR 27-10, October 3, 2011, provides legal support to victims and helps them to

“reduce with an aim toward eliminating sexual offenses within the Army through cultural change, prevention, intervention, investigation accountability, advocacy/response, assessment and training to sustain the All-Volunteer Force.”⁸ The SHARP program maintains a database for formal complaints about sexual harassment alleged by military personnel.⁹ Within OSD, the SHARP program coordinates with ODMEO.

With the creation of a combined SHARP program, the role of proponent for sexual harassment and assault issues shifted from ASA (M&RA) to ARD in the G-1.¹⁰ This transfer was in line with the Army’s adoption of R2 as the conceptual framework for addressing a broad spectrum of behavioral health problems. In FY 2012, oversight of the SHARP program shifted again. Congress directed the Army to put the program under general-officer leadership, albeit still under the aegis of the G-1. The main reason was that, unlike other types of behavioral health problems, sexual assault is always treated as a criminal offense.¹¹ All reported cases involve the Army JAG in investigation and prosecution as appropriate. Putting SHARP under direct military chain of command, Congress argued, would make commanders bear “ultimate responsibility” for command climate and culture, safety, prevention and response efforts, accountability, assessment, and safe reporting.¹²

Three documents provide Army commanders and leaders with guidance on executing SAPR programs. The first is *Strategic Direction to the Joint Force on Sexual Assault Prevention and Response*, which was drawn up by the Joint Chiefs of Staff, the Commandant of the Coast Guard, and DoD SAPR professionals.¹³ Chapter Eight of AR 600-20 describes the SAPR program’s goals and the Army’s sexual assault policy. *Sexual Harassment/Assault Response and Prevention (SHARP) Program Implementation Guidance* lays out required actions and procedures.¹⁴

Funding for the SHARP program covers sexual harassment and sexual assault prevention, training, and tools, as well as 1,000 positions in the Army’s active and reserve components. EO and EEO offices also fund positions at every Army installation to handle complaints of discrimination and sexual harassment, respectively, for service members and civilians. These positions are part of the command structure to ensure leadership involvement in response. Sexual Assault Response Coordinators (SARCs) and Victim Advocates also operate at the local level. SARCs serve as an installation’s primary point of contact for integrating and coordinating sexual assault victim care services for eligible recipients. Reporting directly to the SARC,

seek justice. Headquarters, Department of the Army, *Training: Army Leader Training and Development*, Washington, D.C., AR 350-1, August 19, 2014a, and Headquarters, Department of the Army, *Personnel: General—Army Command Policy*, Washington, D.C., AR 600-20, November 6, 2014b, mandate SAPR training for all personnel and spell out command responsibilities, policy, training requirements, and programs for SAPR and other special issues.

⁸ SHARP, “I. A.M. Strong,” undated.

⁹ The Army EEO Office retains responsibility for civilian reports on sexual harassment and sexual assault, except outside the continental United States, where SHARP also provides assistance to deployed civilians.

¹⁰ Being a proponent carries the responsibility of reporting to the Army Vice Chief of Staff and the USD(P&R).

¹¹ Army and National Guard officials with whom we spoke explained that drug abuse by individual soldiers and DUI might be treated as “misconduct” rather than criminal offenses depending on the severity of the incident and whether it is a repeated offense. Active-duty personnel generally are dealt with in the martial courts, while non-active duty personnel—depending on where the violation allegedly occurred—might be dealt with by local or state law enforcement.

¹² SHARP, undated.

¹³ Joint Chiefs of Staff, *Strategic Direction to the Joint Force on Sexual Assault Prevention and Response*, May 7, 2012.

¹⁴ Department of the Army, 2012.

a Victim Advocate guides the victim of sexual assault through the claim process and provides resources to help the victim recover and resolve the cases against the alleged perpetrator.

Hazing and Discrimination

Hazing and discrimination are both under EO. Effective April 1, 2014, the ASA (M&RA) gained oversight of EO.¹⁵ EO is responsible for the ASA (M&RA)'s diversity and leadership programs for military personnel. Although there is no separate program for hazing, hazing is explicitly banned in AR 600-20.¹⁶

EO officials say they interact regularly, if informally, with other behavioral health programs, including SHARP and programs under ARD. Although EO characterizes its relationship with R2 as largely informal, EO participates in weekly R2 information-sharing teleconference meetings. It also seeks input from the Army JAG Office and ASA (M&RA)'s general counsel on legal issues involved in discrimination, hazing, bullying, and other problematic behaviors.

Responsibility for addressing observed discrimination and offensive behaviors, as well as informal complaints, lies with leaders in the chain of command. An EO manager or EO adviser at the installation level supports commanders to execute responsibilities laid out in AR 600-20.¹⁷ Army EO professionals, along with their peers in other services, receive prevention training at a 12-week DEOMI course located at Patrick Air Force Base.¹⁸

Besides requiring the involvement of leaders in the chain of command to create a positive culture and environment that does not tolerate these problematic behaviors, AR 600-20 requires commanders to record and report all formal complaints in the Equal Opportunity Reporting System (EORS). The EORS collects and maintains data on demographic and other data related to complaints. Major commands must submit quarterly narrative and statistical reports on progress in equal opportunity via the EORS to HQDA for reporting to the Human Resources Directorate in the G-1.¹⁹

Results from command climate surveys executed by DEOMI are used to assess performance and effectiveness of the EO program for military personnel at the brigade, company, and staff office levels. EO program officials explained that sometimes answers in the surveys

¹⁵ EO also has oversight of leadership programs for which ASA (M&RA) has formal responsibility. Also, sexual harassment was under EO before it was made a part of the SHARP program. Awareness training and responding to complaints about sexual harassment are now the responsibility of SHARP.

¹⁶ Although bullying is not one of the six problematic behaviors that are the focus of this study, the latest AR 600-20, published on November 14, 2014, explicitly adds bullying as prohibited conduct and provides a distinct definition for it. Commanders are required to prevent and report bullying like they are with hazing and discrimination. And, like with hazing, there is no separate program for bullying. For full definitions for bullying and hazing and guidance to commanders, see AR 600-20. Also, Assistant Secretary of the Army for Manpower and Reserve Affairs, "Inclusion of Sexual Orientation in the Military Equal Opportunity Program," Army Directive 2015-39, October 14, 2015, adds sexual orientation to the Army's MEO program.

¹⁷ Raymond F. Chandler III, Sergeant Major of the Army, GEN Martin E. Dempsey, U.S. Army Chief of Staff, and John M. McHugh, Secretary of the Army, "Army Equal Opportunity and Discrimination Policy," unaddressed memorandum, undated.

¹⁸ The first eight weeks are common to EO professionals from all services, followed by a week of mediation and alternative dispute settlement training and three weeks of service-specific training. Training also covers use of the EO data system.

¹⁹ For details on the EORS, see Deputy Chief of Staff of the Army, G-1, "Equal Opportunity Reporting System (EORS)," last updated October 7, 2014.

spur questions, which require follow-up interviews or focus groups to obtain clarity on context or insights into hiring and selection decisions.

Suicide Prevention

The Army's Suicide Prevention Program is an integral part of Army R2. AR 600-63 prescribes Army policy for suicide prevention. Department of the Army Pamphlet 600-24, *Personnel: General—Health Promotion, Risk Reduction, and Suicide Prevention*, integrates suicide prevention with Army health promotion and risk-reduction efforts.²⁰ Each installation, Army Reserve direct reporting unit and mission support command, and state joint force headquarters establishes its own suicide prevention task force to plan, implement, and manage the local suicide prevention program.

The G-1 (specifically, Human Resources Health Promotion, Risk Reduction, and Suicide Prevention) oversees the Army Suicide Prevention Program. As the proponent, the G-1 must ensure that Army suicide prevention policy is coordinated and nested with overall DoD suicide prevention efforts. It also represents the Army regarding program issues on the Defense Centers of Excellence Suicide Prevention and Risk Reduction Committee.

The Army Suicide Prevention office, located within ARD, operationalizes the Army Suicide Prevention Program by promoting suicide awareness, prevention, intervention, and post-intervention.²¹ The office was established at the recommendation of the 2009 Army Suicide Prevention Task Force.²² The office has one full-time staff member who is also its director. Like other service prevention program managers, the director supports Army senior leaders as the subject-matter expert on suicide prevention programs, policies, and procedures and develops, implements, and oversees the Army's suicide prevention strategy. To promote communication and coordination within the Army, the office organizes a meeting for representatives of the "big four" (HQDA, IMCOM, NGB, and U.S. Army Reserve) every other week. The agenda for each meeting is set in consultation with these organizations. At these meetings, priorities and emerging issues related to suicide prevention are discussed, and new research and important studies are introduced.

To magnify its influence, the office coordinates with numerous bodies to implement and oversee the Army's suicide prevention strategy. For example, it works with U.S. Strategic Command to develop and deliver messages on suicide prevention to target audiences. It describes relationships overall as "easy" and "open" and stresses that collaborations are generally informal unless they are formal taskers by Army or DoD leaders. The office's principal coordinating partners include ARD (strategy, budgets, and assessment), IMCOM (installation-level suicide prevention), U.S. Army Public Health Center (Provisional) (collection and collation of suicide reports), and DSPO (DoD-level monthly forum).

Substance Abuse

Like other behavioral health programs in the Army, ASAP has the ultimate goal of increasing resilience to enhance combat readiness. AR 600-85, *Personnel: General—The Army Substance*

²⁰ Headquarters, Department of the Army, *Personnel: General—Health Promotion, Risk Reduction, and Suicide Prevention*, Washington, D.C., Department of the Army Pamphlet 600-24, April 14, 2015a.

²¹ Author conversation with senior official directly responsible for Army Suicide Prevention Program on December 2, 2014. See also descriptions related to ASPP in various places in Headquarters, Department of the Army, *Personnel: General—Army Health Promotion*, Washington, D.C., AR 600-63, April 14, 2015b.

²² Gary Sheftick, "Army Creates Suicide Prevention Task Force During 'Stand Down,'" *DoD News*, March 6, 2009.

Abuse Program, provides Army policy on alcohol and other substance abuse. Department of the Army Pamphlet 600-85 provides instructions and procedures for implementing the Army policies provided in AR 600-85.²³

As the proponent for ASAP, the G-1 is responsible for integrating, coordinating, and approving all policies pertaining to ASAP. The director of human resources policy provides guidance and leadership on all nonclinical alcohol and drug policy issues through the director of ASAP. The director of ASAP directs the operation of the Army Center for Substance Abuse Programs. As such, the director is responsible for (1) developing ASAP goals and policies; (2) developing, establishing, administering, and evaluating nonclinical alcohol and other drug abuse prevention, education, and training programs and reviewing, assessing, and recommending policy changes; (3) interpreting ASAP policies for the Army and in response to queries from organizations outside the Army; (4) preparing budget submissions, allocating funds, monitoring execution of resources for ASAP; and (5) overseeing the Army's drug and alcohol testing program.²⁴

In 2010, IMCOM took over lead responsibility from OTSG for implementing substance-abuse policy. The role of Army commanders is to ensure that all officials and supervisors work to support execution of prevention and treatment activities. Other Army entities involved in implementing ASAP are medical review officers, the staff judge advocate, the U.S. Army Criminal Investigation Command, unit prevention leaders, and base area code program managers who oversee drug testing and training.

ASAP has clinical and nonclinical components. The clinical part focuses on regular urinalyses to detect abuses. Alcohol abuse is the most common. Abuse of certain prescription medications, too, has increased in recent years. MEDCOM manages this component and provides treatment and rehabilitation through its clinical director and counselors. The nonclinical part focuses on prevention and intervention. Garrison or command ASAP offices under IMCOM deliver prevention training and risk-reduction programs.²⁵ They are also responsible for collecting, handling, and shipping urinalysis samples.

The Navy Organization to Address Problematic Behavior: The 21st Century Sailor and Marine Office

As was the case with the Army, the Navy's approach to combating problematic behavior is increasingly integrated and holistic, based on a deliberate decision to organize all relevant programs into a single office, N17. This office includes a wide range of programs that deal with many aspects of readiness. The Navy's approach to addressing problematic behavior is characterized by viewing behaviors along a spectrum and by focusing efforts on establishing the

²³ Headquarters, Department of the Army, *Personnel: General—Army Substance Abuse Program Civilian Services*, Washington, D.C., Department of the Army Pamphlet 600-85, October 15, 2001; Headquarters, Department of the Army, *Personnel: General—The Army Substance Abuse Program*, Washington, D.C., AR 600-85, December 28, 2012. Other important laws, instructions, policy, and guidance for the program can be found at ASAP, home page, undated.

²⁴ Clinical treatment for substance abuse is MEDCOM's responsibility as defined in MEDCOM Regulation 40-51.

²⁵ These ASAP offices are typically staffed with alcohol and drug control officers, prevention coordinator, installation biochemical test coordinator, employee-assistance program coordinator, and a risk-reduction program coordinator.

right climate at the command level. Within the Navy's organizational structure, N17 is part of OpNav.²⁶

N17 was established as a new directorate in June 2013, with the specific goal of integrating the Navy's programs and objectives focused on sailor readiness and family readiness. Specifically, N17 is designed as the CNO's principal adviser on readiness issues and as a single entity to create a more comprehensive policy approach to readiness issues.²⁷ Thus, the design of N17 is policy-centric (rather than, for example, including only programs focusing on problematic behavior). Despite this, discussants use a common language, based on behavioral models; in particular, they view suicide and sexual assault as things that occur at the end of a whole chain of behaviors.²⁸ This suggests that an entire continuum of behaviors is linked to harm. Discussants used such phrases as "continuum of harm" and the need to address behaviors "to the left" (early on in the continuum) to describe the relationships between various behaviors. They reported that evidence from the social science literature supports this view; one mentioned CDC's research in particular.²⁹

N17 includes six branches (or programs):

- Total Sailor Fitness (drug and alcohol prevention, as well as numerous programs that deal with physical readiness and family readiness, including transition support)
- Suicide Prevention and Operational Stress Control
- SAPR
- Sexual Harassment Prevention and Equal Opportunity
- Behavioral Standards (hazing and fraternization)
- Policy and Resource Coordination.³⁰

Personnel in N17 focus on the command level. The commander is viewed as holding responsibility for establishing and maintaining the correct "climate," and problematic behavior is viewed as occurring more frequently when the climate allows this. For example, a climate that permits stereotypes might eventually result in sexual harassment or sexual assault. Job-related stress and alcohol use are thought to be key factors as well. In terms of suicide, periods of transition and times with low levels of social connection can be triggers. Finally, fatigue and alternate watch schedules are triggers for stress injuries and perhaps for problematic behav-

²⁶ The CNO, the Vice Chief of Naval Operations, the Deputy Chiefs of Naval Operations, and certain other ranking officers and their staffs are collectively known as OpNav.

²⁷ See Battaglia, 2014.

²⁸ Our policy discussions included only personnel who work on problematic behavior. We did not speak with anyone from the Fleet and Family Support, Physical Readiness, or Exceptional Family Member Programs. These programs and others are included within Total Sailor Fitness along with Navy Drug and Alcohol Prevention. For more information about organization of programs, see Battaglia, 2014.

²⁹ No specific reference was provided, but the literature does suggest a correlation between suicide and health and intimate-partner problems. For example, see Debra L. Karch, Joseph Logan, Dawn McDaniel, Sharyn Parks, and Nimesh Patel, "Surveillance for Violent Deaths: National Violent Death Reporting System, 16 States, 2009," *Surveillance Summaries*, Vol. 61, No. SS06, September 14, 2012, pp. 1–43; for the correlation between suicide and job and financial issues among middle-aged adults, see Katherine A. Hempstead and Julie A. Phillips, "Rising Suicide Among Adults Aged 40–64 Years: The Role of Job and Financial Circumstances," *American Journal of Preventive Medicine*, Vol. 48, No. 5, May 2015, pp. 491–500.

³⁰ The specifics of the establishment of N17 and the organization of branches within are drawn from NAVADMIN 153/15, and Battaglia, 2014.

ior. To some extent, this command-centric view might reflect the varied circumstances in which sailors serve (on submarines, on aircraft carriers, on smaller ships, on shore, in overseas locations).³¹ Personnel in N17 view consolidated training within all N17 codes (or as many N17 codes as is practical) to be both effective and efficient. Their goal is to have training that is not redundant so sailors actually spend less time in training but gain more useful information.

Along with improving training, personnel in N17 view establishing consistent and integrated sources of data as central to their efforts. For example, prior to this office being established, programs had completely independent databases (e.g., one for hazing, one for sexual assault). With the office in place, a goal is to develop a single database that will track a wide variety of problematic behaviors. This would allow analysis at the command level, consistently with the office's focus. For this reason, personnel across N17 are working to standardize various types of data collection—for example, standardizing questions and measures across surveys and polls that touch on the same subjects could make information comparable and, thus, more useful.

Another theme across the policy discussions involved the tone of messaging to the fleet. Personnel in N17 strive to create positive messages because they believe that these messages are best received and are most likely to be effective. For example, a positive message might focus on living life to the fullest rather than avoiding suicide or on maintaining the rank the sailor worked hard to achieve by avoiding poor decisions while drinking, rather than avoiding alcohol completely.

In general, the lines of oversight and authority for programs focused on problematic behavior within the Navy are clear. A NAVADMIN established N17 in 2013. The specific programs that focus on problematic behavior were established or updated, usually by OpNav instructions (lawful orders issued by the CNO). In some cases, Secretary of the Navy instructions (lawful orders issued by the secretary) were used to establish policy that applied to both the U.S. Navy and the U.S. Marine Corps. There appears to be no confusion within programs related to Navy oversight or authority. In at least one case (MEO), the directive was originally issued in 1995 and since has been updated only through memos. Navy MEO program officials expressed a desire for an updated instruction from OSD that would replace obsolete information.

The organization of policy, resource, and legislative personnel into a single office (N17C Policy and Resource Coordination) seems to encourage collaboration among the six constituent programs (although the fact that the office has two locations, in Millington, Tennessee, and Arlington, Virginia, means that much of this occurs over the phone or through other virtual means). Aside from working with Suicide Prevention, Hazing, Operational Stress Control, and Drug and Alcohol Prevention, the Navy SAPR program reports interacting with the Naval Criminal Investigative Service, the Navy Bureau of Medicine and Surgery (BUMED), the chaplains, U.S. Fleet Forces Command, the Department of the Navy SAPR office, the Marine Corps SAPR office, and occasionally universities. These interactions are mostly informal and ad hoc, and our discussion protocol did not capture the set of uses discussed in these interactions. The Navy SAPR office also reports that the OSD SAPR office serves as a forum for sharing best practices.

³¹ Indeed, one discussant stated that there are five separate “navies”: ships, subs, special ops, cyber, and onshore.

The sexual harassment program in MEO reports working with many other organizations within the Navy. In many cases, coordination is not surprising because of obvious overlap in subject area (for example, between SAPR and BUMED). However, some organizations have less obvious areas of overlap. For example, the sexual harassment program recently collaborated with DEOMI on translating a climate survey for Japanese civilian workers. This program also interacts with the Marine Corps and the Army; it has less interaction with the Air Force.³² The program also collaborates with ODMEQ, but the amount of interaction is limited by the fact that ODMEQ's sexual harassment office is a one-person shop. Although some of the program's collaborative efforts are formal—in particular, interservice working groups—discussants could not point to any regular products that result from these interactions. Program personnel suggested that a (DoD-wide) standard database for tracking sexual harassment would be helpful. At the same time, personnel from other programs within N17 emphasized the plan to build an N17-specific database to track a variety of problematic behaviors; again, this is viewed as a key potential measure of command climate and leadership.

The Navy hazing program reports that definitions are problematic. In particular, the distinction between hazing (an inclusive behavior) and bullying (an exclusive behavior) is often unclear initially; personnel reported that bullying actually appears to be more common than hazing and indicated their understanding that this is the case in other services as well. Navy hazing program personnel also report extensive collaboration with other N17 programs but little work with OSD (aside from a working group on hazing). This final point is consistent with the earlier finding that the hazing working groups within DoD have few partners, as noted in Chapter Three.

The Navy Drug and Alcohol program also reports interacting with many other Navy organizations; examples include BUMED, the Navy and Marine Corps Public Health Center, and Navy- and OSD-led working groups on alcohol and drug issues. Finally, this program has worked with the base exchanges to minimize the placement of alcohol for sale and with minimarts on bases to remove grain alcohols and reduce hours during which alcoholic beverages are offered for sale.

Suicide Prevention and Operational Stress Control works closely and frequently with Navy Drug and Alcohol and with Command Fitness, as well as with the Navy and Marine Corps Public Health Center, BUMED, and the Navy chaplains. The program also manages a crisis line together with Veterans Affairs.

Many programs within N17 also report significant engagement with the Navy fleet. In particular, the CNO mandates that all leadership within deploying units receive specific operational stress control training; this involves significant interaction with the fleet. In general, with the exception of mandated training, most of these interactions are ad hoc and informal.

Across the policy discussions, participants repeatedly mentioned time and travel budgets as the limiting factors in collaboration—with more time and more funds, they would elect to carry out more collaboration with a variety of groups, but especially with other organizations within DoD.

³² MEO personnel indicated that differences in structure between the Navy and the Air Force were a reason for the lower level of interaction—in particular, enlisted MEO personnel within the Air Force have their own career field; officers who work on MEO issues are considered personnelmen, but chiefs and deputy directors of MEO have specific functional account codes.

Marine Corps Organizations to Address Problematic Behavior

Behavioral Health Program

The Marine Corps approach to reducing problematic behavior is characterized by integrating efforts, with a focus on unit-based approaches and creating training that aims to be effective and efficient. In particular, the Marine Corps deliberately combined efforts focused on suicide prevention, family advocacy, substance abuse, operational stress control, and sexual assault into the Behavioral Health Program in 2010.

Marine Corps officials selected the integrated behavioral health approach for several reasons. First, they recognized that many problematic behaviors have common risk and preventive factors. Second, they realized that young male junior enlisted personnel, who make up a large fraction of marines, are at high risk for many problematic behaviors.³³ Third, they wanted to increase the efficiency of training by addressing multiple behaviors simultaneously. Fourth, they hoped to more accurately measure problematic behavior by integrating data systems and tracking.

The decision to integrate behavioral health programs within the Marine Corps was carried out just as the deployment cycle began to wane in anticipation of an increased need for psychological services for marines and their families. In 2010, the commandant's planning guidance called for recommendations on how best to integrate behavioral health efforts, and integration occurred largely in 2011.³⁴ Despite these efforts, the Marine Corps integration strategy has not included sexual assault, sexual harassment or discrimination, or hazing.³⁵ Nonetheless, our policy discussions suggest that the Marine Corps has encouraged coordination among behavioral programs inside and outside the Behavioral Health Program.

Although it is no longer officially part of the behavioral health program, the Marine Corps SAPR program works quite closely with the Behavioral Health Program. The Marine Corps hazing program and the EO program are also organized outside the behavioral health "umbrella." In May 2013, a Marine Corps order from the commandant stood up the hazing program³⁶ to ensure that hazing does not occur within the Marine Corps. This occurred in response to a specific incident, and the commandant made the decision to keep the program separate from other programs to facilitate tracking. The Marine Corps Sexual Harassment program is part of the Marine Corps MEO program.³⁷ Although it is not part of the behavioral health branch, it reports substantial coordination with behavioral health programs.

Behavioral Health Coordination and Oversight Mechanisms

The main coordination and oversight mechanism for addressing problematic behavior within the Marine Corps is the organization of several relevant programs into the Behavioral Health

³³ Compared with members of the other services, marines are young; about two-thirds of enlisted personnel and more than 60 percent of the entire active component are age 25 or younger. Also, Marine Corps personnel have experienced significant levels of deployment in the past 14 years. Therefore, we might expect that the corps' approaches to reducing problematic behavior will differ somewhat from the approaches that the other services take; the other services might face different challenges because of differences in age, family structure, and deployment experience of their members.

³⁴ 35th Commandant of the Marine Corps, *Commandant's Planning Guidance 2010*, c. 2010.

³⁵ In part, this is because Congress decided that Marine Corps commanders were not doing enough to prevent incidences of sexual assault and demanded a separate program to address this behavioral problem.

³⁶ See Commandant of the Marine Corps, "Hazing," Marine Corps Order 1700.28B, May 20, 2013.

³⁷ The current relevant order is Commandant of the Marine Corps, "Sexual Harassment," Marine Corps Order 1000.9A, May 30, 2006.

Program. According to service personnel's understanding of the literature, the Marine Corps model views many of the problematic behaviors included in these programs as interrelated and as having the potential to occur together and to lead toward very negative outcomes. Especially in the presence of triggers, such as permanent change of station or other transitions,³⁸ relationship breakdowns, disciplinary actions, job-related stress, or substance abuse, this model recommends increased vigilance and the use of protective factors found in training and education to prevent suicide attempts (and other problematic behavior). The behavioral health model also recognizes a series of demographic risk factors—in particular, young males of junior enlisted ranks are at risk for a wide variety of potentially destructive behaviors. Also, the model explicitly recognizes that the use and misuse of alcohol are associated with many other problematic behaviors and spill over into many other behaviors—examples provided include motorcycle safety and sexual assault.³⁹ Therefore, the behavioral health model attempts to deal with all these behaviors in an integrated fashion. Best practices include embedding clinical providers at the marine expeditionary force or unit level (similar to the Army's risk-reduction coordinators).

To integrate behavioral health programs, the Marine Corps elected to combine program personnel by functional area rather than discipline; in particular, the policy analysts from each program now work together as a team, as do the data analysts from each program. This has allowed better integration of both data and policy. Integrating the data analysts was viewed as a necessity, both to better advocate for resources and to track progress in a more holistic manner. Behavioral health personnel also report having built logic models for their programs and tracking a variety of measures. Of course, they track such negative outcomes as suicides, family violence, and DUIs, as well as a variety of outputs, such as training completed. A memorandum of understanding with the Wounded Warrior Project, a nonprofit organization dedicated to assisting injured veterans, enables behavioral health programs to utilize an existing data platform to track key outputs and outcomes. Program managers are trying to determine how to measure the success of their integration efforts. A key long-term goal is to develop ways to evaluate combined, unit-level training programs that cover all relevant problematic behaviors.

Coordination in Other Marine Corps Programs

As previously indicated, the Marine Corps SAPR program is not officially a part of the Behavioral Health Program. Although SAPR has a separate budget and reporting requirements, it is funded through Behavioral Health and is able to tap into behavioral health resources as necessary. Specific examples include the use of legal counsel, as well as working with behavioral health counselors and victim advocates as necessary. The SAPR program works with the quality assurance and financial branches of Behavioral Health to ensure data quality, as well as with substance-abuse and alcohol programs. SAPR works closely with EO (sexual harassment) and with judicial and criminal branches (i.e., Marine Corps Legal Services and Naval Criminal Investigative Service). This program also works closely with relevant personnel in DoD and OSD. In most cases, these relationships are informal in nature. This approach seems to work well for this program.

³⁸ In particular, transitions have been noted as being linked to suicides; for this reason, behavioral health personnel are currently planning to begin working more closely with the program that covers transition assistance (Personal and Professional Development). Note that transitions are considered a "high-risk area" rather than a problematic behavior.

³⁹ As discussed later in this appendix, those working on problematic behavior within the Marine Corps report that OSD's highly stovepiped approach to alcohol- versus drug-related issues means that having an integrated approach at the service level is more difficult; in particular, OSD's funding requirements are thought to be restrictive.

Coordination is particularly challenging in the case of sexual assault. Discussants drew a sharp distinction between sexual assault, which is a crime, and sexual harassment, which is not. Marine Corps officials contend that personnel in all the services must be trained to recognize this distinction and its consequences for program execution. Although SAPR is required to provide stand-alone training, SAPR officials believe that certain elements of this training could also be incorporated into other programs' training activities, thereby mitigating multiple problematic behaviors, including sexual assault.

The hazing program within the Marine Corps is very small; hazing makes up a minor fraction of one person's portfolio. Although the intended purpose of the program and the lines of authority are very clear, the line between hazing, bullying, and harassment, in particular, can appear blurred in practice, making coordination with related programs desirable. Hazing personnel do, in fact, collaborate with counterparts in the SAPR and sexual harassment programs. One example of this collaboration is MEO's discrimination and sexual harassment incident-tracking platform that is also used to track hazing. The fact that the hazing and sexual harassment programs report to the same SES official also facilitates coordination between them. That said, the newness of the hazing program and its limited resources have limited its interactions with other programs.

The sexual harassment program operates in a very decentralized manner; commanders at major commands essentially own and execute the program, which primarily consists of mandated training and (currently) an annual report mandated by the NDAA. The program is small, consisting of two subject-matter experts and a branch head. Program personnel coordinate frequently with the Marine Corps SAPR and hazing offices (as mentioned previously), as well as with the Navy MEO and OSD MEO. Finally, they collaborate with DEOMI on educational curriculum development.

In sum, discussants indicated that coordination and oversight mechanisms within the Marine Corps work well from their perspective, including programs that are part of the Behavioral Health Program *and* programs focused on problematic behavior that is not part of the Behavioral Health Program. As the examples above demonstrate, coordination mechanisms between such programs within the Marine Corps tend to be informal but frequently utilized. This might be partly a function of the small size of many Marine Corps programs. In addition, lines of authority tend to be quite clear, and there are relatively few bureaucratic layers.

Air Force Organizations to Address Problematic Behavior

Although there is no overarching organization in the Air Force comparable to ARD or N17, its emergent holistic perspective to problematic behavior and R2 is embodied in a multilayered set of intra-agency oversight and coordination organizations—CAIBs, IDSs, and CAF—and a central point of contact in Air Force Headquarters. However, Air Force Headquarters and installations still maintain discrete organizations to handle each problematic behavior, in keeping with the largely historical management scheme and with a structure that largely parallels OSD's structure.

Comprehensive Airman Fitness, Community Action Information Boards, and Integrated Delivery Systems

CAF, CAIBs, and IDSs provide venues for intraservice coordination and oversight of initiatives pertaining to problematic behavior and overall airman well-being. Established in 2011, CAF is modeled on the Army's larger and longer-running Comprehensive Soldier and Family

Fitness program. Currently consisting of one airman and one civilian located in Air Force Headquarters, and two full-time training staff members stationed off-site, CAF manages the agenda and actions of the Air Force CAIB (chaired by AF/CVA) and the training program for the Master Resilience Trainers, who provide wing-level services to airmen for improved resilience.⁴⁰ Because of their small number, CAF personnel are limited in the amount of direct coordination they can do.

Although they lack line management authority, the CAIBs and IDSs are oversight and coordination forums for the entire range of issues related to the well-being of Air Force personnel. The CAIBs exercise their oversight responsibilities via management leads, while the IDSs employ functional leads. At the apex of these two organizations are the Air Force Chief of Staff, Vice Chief of Staff, and AF/CVA. The headquarters-level CAIB is chaired by AF/CVA—with the CAF lead serving as the CAIB executive director—and the members include all the Air Staff heads (e.g., AF/A1), staff leads from the Air Force Secretariat organizations, and the IDS chair. This organization meets at least two times per year and considers issues that the IDS, CAF, and lower-level CAIBs and IDSs cannot resolve. The headquarters-level IDS meets at least quarterly to consider Air Force-wide issues related to the delivery of services intended to improve airman R2 and well-being. IDS functional leads (including those from organizations to address problematic behavior) propose changes or solutions, which are referred to the CAIB for ultimate decision. In some cases, issues are assigned by the CAIB; in other cases, they are raised by IDS members or lower-level CAIBs and IDSs. The IDS chair is appointed by AF/CVA from among the IDS members on a rotational basis.

The establishment of the CAIB, IDS, and CAF reflect an acknowledgment by Air Force leadership that problematic behavior and other issues affecting airman well-being often have significant overlap and might be better addressed in an integrated fashion. Additionally, the multilayered structure of the CAIB and IDS is designed to (1) solicit more insights from installations and functional levels at which services are delivered and (2) provide more feedback about headquarters-level actions. One specific issue requiring a more integrated service response is “survey fatigue,” which results from a lack of coordination among different levels of Air Force management and different functional organizations. According to one discussant, the staff working for AF/A1 has made recent efforts to combine surveys and to make clear, up front, the purpose of the surveys—resulting in higher response rates. And Air Force leadership, in turn, is purportedly trying to reference surveys and other analytic mechanisms that were used as the impetus for institutional changes to demonstrate the benefits of and build support for these data-collection efforts.

⁴⁰ Air Force Instruction 90-501.

Air Force Behavioral Health Coordination and Oversight Mechanisms

In addition to CAF, CAIB, and IDS, the Air Force has organizations for managing efforts to reduce specific problematic behavior. These organizations include the following:

- EO⁴¹ for sexual harassment and discrimination
- SPP⁴²
- Psychological Health:⁴³ treatment for substance use and suicide prevention, including the Alcohol and Drug Abuse Prevention and Treatment (ADAPT) program⁴⁴
- the DDRP⁴⁵ for prevention and detection of illegal drug use
- SAPR⁴⁶ for prevention of and response to sexual assault, including victim advocates.

By law, the EO organization handles the sexual harassment and discrimination activities of the Air Force, including overseeing installation-level EO staff, moving harassment and discrimination claims through the process, and collecting and disseminating required data. The headquarters EO staff consists of three full-time civilians and four full-time active-duty personnel, with two designated lead civilians for sexual harassment and discrimination.

The suicide prevention program develops training, writes policy, and coordinates research related to suicide prevention. This includes managing the Air Force contribution to the DoDSER and providing clinical guidelines for suicide prevention. The program consists of two active-duty personnel within Air Force headquarters.

The director of psychological health position (an active-duty airman) was created in accordance with DoDI 6490.09⁴⁷ and works on improving mental health service delivery for Air Force personnel, including services related to suicide prevention and substance use. The director has one direct subordinate who oversees the lower-echelon deployment mental health

⁴¹ Assistant Secretary of the Air Force for Manpower and Reserve Affairs, "Personnel: Diversity," Air Force Policy Directive 36-70, October 13, 2010; Headquarters, Air Force Personnel Center, *Equal Opportunity, Personnel: Equal Opportunity Program Military and Civilian*, Air Force Instruction 36-2706, October 5, 2010; Deputy Chief of Staff of the Air Force for Manpower, Personnel and Readiness, *Personnel: Nondiscrimination in Programs and Activities Assisted or Conducted by the Department of the Air Force*, Washington, D.C., Air Force Instruction 36-2707, December 16, 2010, certify current January 7, 2015.

⁴² Air Force Special Needs Program Manager, Air Force Medical Operations Agency, *Medical: Suicide and Violence Prevention Education and Training*, Air Force Instruction 44-154, January 3, 2003; Healthcare Operations, Air Force Medical Support Agency, *Special Management: Suicide Prevention Program*, Air Force Instruction 90-505, August 10, 2012; Healthcare Operations, Air Force Medical Support Agency, *Special Management: Suicide Prevention Program*, Air Force Instruction 90-505, October 6, 2014.

⁴³ Medical Service, Air Force Medical Operations Agency, *Medical Operations: Mental Health*, Air Force Instruction 44-172, March 14, 2011a; Medical Service, Air Force Medical Operations Agency, *Medical Operations: Mental Health*, Air Force Instruction 44-172, November 13, 2015; Medical Service, Air Force Medical Operations Agency, "Guidance Memorandum to Air Force Instruction (AFI) 44-172, Mental Health," August 5, 2014b.

⁴⁴ Medical Service, Air Force Medical Operations Agency, *Medical: Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program*, Air Force Instruction 44-121, April 11, 2011b; Medical Service, Air Force Medical Operations Agency, *Medical: Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program*, Air Force Instruction 44-121, July 8, 2014a.

⁴⁵ Air Force Instruction 44-120, "Military Drug Demand Reduction Program," June 6, 2012; and "Air Force Guidance Memorandum to Air Force Instruction (AFI) 44-120, Military," Surgeon General of the Air Force, dated January 30, 2014.

⁴⁶ Air Force Sexual Assault Prevention and Response Office, "Sexual Assault and Prevention and Response (SAPR) Program," Air Force Policy Directive 36-60, March 28, 2008a; Air Force Sexual Assault Prevention and Response Office, "Sexual Assault Prevention and Response (SAPR) Program," Air Force Instruction 36-6001, September 29, 2008b.

⁴⁷ DoDI 6490.09.

and suicide prevention program managers. Located within the Office of the Air Force Surgeon General, the director also oversees policy and implementation of the ADAPT program, which provides installation-level services to those who are alleged to have, or who admit to having, alcohol or drug problems.

The DDRP carries out the required annual testing of all active-duty airmen for illicit-drug use. The Air Staff lead under the Air Force Surgeon General collects data and disseminates policy and procedural changes. At the installation level, DDRP staff members (a mix of active-duty staff and civilians) report to the wing commander, perform the testing, refer positive results to the local clinical services in the installation-level ADAPT program for possible treatment, and report data to headquarters.

The SAPR program develops policy and training, ensures training occurs, collects data, oversees installation-level sexual assault response coordinators and victim advocates, and performs intra-agency and interagency roles geared toward reducing the frequency of sexual assault and improving reporting and case management. The headquarters SAPR office, which is the largest by far among the headquarters staff organizations to address problematic behavior, has about 30 full-time staff members—a mix of active-duty and civilian personnel. The SAPR program now directly reports to AF/CVA, after previously reporting up through AF/A1 until the middle of 2013. As a result of public and leadership interest in reducing sexual assault, the SAPR program is the largest and most interdisciplinary organization in the Air Staff to address problematic behavior. As of this writing, the SAPR program was finishing work on a new strategic plan.

Acknowledgments

We thank Clarence A. Johnson, director, Office of Diversity Management and Equal Opportunity, Office of the Under Secretary of Defense for Personnel and Readiness, and senior members of his staff, especially Beatrice Bernfeld, for sponsoring, guiding, and contributing to this research. Numerous people outside RAND assisted us by attending our problematic-behavior workshop, providing research materials, participating in discussions regarding their organizations, and offering corrections and suggested changes to interim briefings and reports. In particular, we would like to acknowledge the cooperation of leaders and staff members in the Under Secretary of Defense for Personnel and Readiness Sexual Assault Prevention and Response (SAPR) Office, Defense Suicide Prevention Office, and Drug Demand Reduction Program; the Office of the Assistant Secretary of Defense for Health Affairs; the Defense Health Agency; the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury; and the Joint Staff High-Risk Behavior Working Group.

For the Army, we offer our thanks to officials in the Sexual Harassment/Assault Response and Prevention program; the Suicide Prevention Program; the Army Equal Opportunity Program; the Army Substance Abuse Program; and the Army Resiliency Directorate.

For the Navy, we extend our appreciation to officials within the 21st Century Sailor and Marine Office, as well as to program personnel working on sexual harassment and equal opportunity, hazing, SAPR, and suicide prevention and operational stress control.

For the Marine Corps, we wish to thank officials within the Behavioral Health Program, as well as within the SAPR, Hazing, and Sexual Harassment/Discrimination programs.

For the Air Force, we gratefully acknowledge the assistance of those working in the following organizations: Comprehensive Airman Fitness; the Drug Demand Reduction Program; Air Force Equal Opportunity; the Department of the Air Force Office of the General Counsel; the Integrated Delivery System; the Air Force Medical Support Agency; the Air Force SAPR Office; and the Air Force Suicide Prevention Program.

We are also indebted to our RAND study senior adviser, Rajeev Ramchand, and our reviewers, Andrew R. Morral and Maria C. Lytell, for their helpful comments on this report, as well as to Theresa DiMaggio for formatting and compiling the bibliography for this document.

Abbreviations

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|------------|---|
| ADAPT | Alcohol and Drug Abuse Prevention and Treatment |
| AF/A1 | Air Force Deputy Chief of Staff for Manpower, Personnel and Services |
| AF/CVA | Air Force Assistant Vice Chief of Staff |
| AR | Army regulation |
| ARD | Army Resiliency Directorate |
| ASAP | Army Substance Abuse Program |
| ASA (M&RA) | Assistant Secretary of the Army for Manpower and Reserve Affairs |
| ASD | assistant secretary of defense |
| ASD(HA) | Assistant Secretary of Defense for Health Affairs |
| ASD(M&RA) | Assistant Secretary of Defense for Manpower and Reserve Affairs |
| ASD(R&FM) | Assistant Secretary of Defense for Readiness and Force Management |
| BUMED | Navy Bureau of Medicine and Surgery |
| CAF | Comprehensive Airman Fitness |
| CAIB | community action information board |
| CDC | Centers for Disease Control and Prevention |
| CNO | Chief of Naval Operations |
| DASD | deputy assistant secretary of defense |
| DASD(R) | Deputy Assistant Secretary of Defense for Readiness |
| DCoE | Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury |
| DDRP | Drug Demand Reduction Program |
| DDWG | Defense Diversity Working Group |
| DEOCS | Defense Equal Opportunity Management Institute Organizational Climate Survey |

| | |
|--------|--|
| DEOMI | Defense Equal Opportunity Management Institute |
| DHA | Defense Health Agency |
| DHRA | Defense Human Resource Activity |
| D&I | Diversity and Inclusion |
| DoD | U.S. Department of Defense |
| DoDD | Department of Defense directive |
| DoDI | Department of Defense instruction |
| DoDSER | U.S. Department of Defense Suicide Event Report |
| DSM | Diagnostic and Statistical Manual of Mental Disorders |
| DSM-5 | Diagnostic and Statistical Manual of Mental Disorders, 5th ed. |
| DSPO | Defense Suicide Prevention Office |
| DUI | driving under the influence |
| EEO | equal employment opportunity |
| EO | equal opportunity |
| EORS | Equal Opportunity Reporting System |
| FY | fiscal year |
| G-1 | Deputy Chief of Staff of the Army for Personnel |
| HEC | Health Executive Council |
| HQDA | Headquarters, Department of the Army |
| HR | human resource |
| HRB | Health Related Behaviors |
| IDS | Integrated Delivery System |
| IED | intermittent explosive disorder |
| IMCOM | U.S. Army Installation Management Command |
| IMHS | Integrated Mental Health Strategy |
| IOM | Institute of Medicine |
| IPT | integrated product team |
| JAG | judge advocate general |
| JCS | Joint Chiefs of Staff |
| JEC | Joint Executive Council |

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| LOE | line of effort |
| MDD | major depressive disorder |
| MEDCOM | U.S. Army Medical Command |
| MEO | military equal opportunity |
| N17 | 21st Century Sailor and Marine Office |
| NAVADMIN | naval administrative message |
| NDAA | National Defense Authorization Act |
| NDRI | RAND National Defense Research Institute |
| NGB | National Guard Bureau |
| ODMEO | Office of Diversity Management and Equal Opportunity |
| OpNav | Office of the Chief of Naval Operations |
| OPR | office of primary responsibility |
| OSD | Office of the Secretary of Defense |
| OTSG | Office of the Surgeon General |
| PHC | Psychological Health Council |
| PTSD | posttraumatic stress disorder |
| R2 | Ready and Resilient |
| RCT | randomized controlled trial |
| RRP | Risk Reduction Program |
| SAPR | sexual assault prevention and response |
| SAPRO | Sexual Assault Prevention and Response Office |
| SES | Senior Executive Service |
| SHARP | Sexual Harassment/Assault Response and Prevention |
| SOS | Signs of Suicide |
| SPARRC | Suicide Prevention and Risk Reduction Committee |
| SPGOSC | Suicide Prevention General Officer Steering Committee |
| SUD | substance-use disorder |
| USD(P&R) | Under Secretary of Defense for Personnel and Readiness |
| VA | U.S. Department of Veterans Affairs |
| VAWA | Violence Against Women Act |

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Pressures inside and outside the U.S. Department of Defense (DoD) to reduce the incidence of problematic behaviors within the military are inducing the Office of the Secretary of Defense to rethink how it is organized to oversee and coordinate DoD's varied behavior-mitigation efforts. This report provides the results of a RAND study that examined the integration of programs for addressing a specified set of problematic behaviors: sexual harassment, sexual assault, unlawful discrimination, substance abuse, suicide, and hazing. The report combines the results of the two major lines of research: the first related to the development of a typology of common problematic behavior risk and protective factors and prevention methods based on a review of the behavioral science literature, and the second related to the organization, coordination, oversight, and managerial practices of programs to address problematic behavior based on document analysis and policy discussions with DoD and service headquarters officials. Following a discussion of findings from the two lines of research, the report lays out a series of recommendations for the Office of the Secretary of Defense to improve its understanding of the interrelationships among problematic behaviors and its oversight and coordination of programs to address those behaviors.



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ISBN-10 0-8330-9568-4
ISBN-13 978-0-8330-9568-8

